Directory

If you have questions about…	Contact…
Medical/Surgical Issues	Uniform Medical Plan PPO (UMP PPO) Customer Service 1-800-762-6004 or 425-670-3000 (Seattle area), Monday-Friday, 8 a.m. to 6 p.m.
Appeals, First Level; Correspondence, Complaints, Preauthorization, Medical Review	Uniform Medical Plan PPO P.O. Box 34578 Seattle, WA 98124-1578 Fax: 425-670-3197
Benefit Information, Certificates of Coverage, I.D. Cards, Claim Forms, Claims Status	Uniform Medical Plan P.O. Box 34850 Seattle, WA 98124-1850 **www.ump.hca.wa.gov**
Finding a Network Provider	For services in: **Washington and Idaho border counties** of Bonner, Kootenai, Latah, and Nez Perce: 1-800-762-6004 or 425-670-3000 (Seattle area) or **www.ump.hca.wa.gov** **Other U.S. locations (Beech Street):** 1-800-432-1776 or **www.beechstreet.com**
Prescription Drugs **Member Services, Network Pharmacies, Preferred Drugs Questions, Complaints**	Express Scripts, Inc. **www.express-scripts.com** 1-866-576-3862 Available 24 hours a day, 7 days a week
First-Level Appeals, Correspondence	Express Scripts, Inc. Attn: Pharmacy Appeals: WA5 Mail Route BLO390 6625 West 78th Street Bloomington, MN 55439 Fax: 1-877-852-4070 Enrollee phone: 1-866-576-3862 Provider phone: 1-800-417-8164
Drug Coverage Management and Preauthorization	1-800-417-8164 Provider to call on enrollee's behalf
Mail-Service Pharmacy (refills)	Express Scripts, Inc. **www.express-scripts.com** 1-866-576-3862
Claims from Non-Network Pharmacies	Express Scripts, Inc. WA5A P.O. Box 390873 Bloomington, MN 55439-0873
Case Management	1-888-759-4855
Eligibility and Enrollment	PEBB Benefits Services 1-800-200-1004 or 360-412-4200 Fax: 360-923-2602 Monday-Friday, 8 a.m. to 5 p.m. **www.pebb.hca.wa.gov**
Preventive Care Guidelines	**www.ahcpr.gov/clinic/gcpspu.htm** **www.cdc.gov/nip/publications/ACIP-list.htm**
Tobacco Cessation	*Free & Clear* 1-800-292-2336 Monday-Friday, 8 a.m. to 6 p.m. **www.freeandclear.org/brochure**
Address Changes	Contact your personnel, payroll, or insurance office
Washington Hotline Numbers	Alcohol and Substance Abuse 1-800-562-1240 Domestic Violence 1-800-562-6025 Emergency Contraception 1-888-668-2528 Family Planning 1-800-770-4334 HIV-AIDS (national) 1-800-342-2437 Poison Control 1-800-732-6985

To obtain this booklet in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

To Learn More About... See Page...

(continued on next page)

To Learn More About... See Page...

To Learn More About... See Page...

This booklet explains benefit provisions specific to the UMP PPO and is the certificate of coverage for UMP PPO enrollees. (This certificate of coverage supersedes previous certificates.)

If provisions in this booklet are inconsistent with any federal or state statute or rule, the language of the statute or rule will govern.

This booklet was compiled by the Washington State Health Care Authority/Uniform Medical Plan, PO Box 91118, Seattle, WA 98111-9218. If you have any questions about these provisions, please contact the UMP PPO (see the Directory).

Highlights

Welcome to the Uniform Medical Plan Preferred Provider Organization (UMP PPO)! The UMP PPO is a self-insured plan designed by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA). Your coverage through UMP PPO gives you access to one of the largest provider networks in Washington State, as well as care from out-of-state networks in most other parts of the country.

This plan is designed to keep you and your family healthy in addition to providing benefits in case of illness or injury. As you know, your health care coverage can be one of your most important benefits. Please review this booklet carefully so that you can take advantage of all this plan has to offer. In addition, you can visit the UMP Web site at **www.ump.hca.wa.gov** to access the following:

- Online accounts, where you can access your medical and pharmacy claims information through secure Web sites.
- Secure e-mail to submit questions to Customer Service (through your online account).
- Benefits information.
- Prescription drug and pharmacy network information.
- Provider network directories.
- UMP publications and forms.
- Links to health resources and Medicare information.
- Explanations of complaints and appeals processes.
- Frequently asked questions.

UMP PPO Features

Here are a few important plan features:

- When covered by the UMP PPO, you can choose to see network, out-of-network, or non-network providers. These different options are described on pages 14-15, along with the coverage differences.
- In most cases, the UMP PPO allows you to self-refer for services from network, out-of-network, and non-network providers belonging to any approved provider type (see list beginning on pages 18-19).
- Worldwide coverage for nonemergency and emergency care is a definite plus when you travel. Refer to "Your Medical/Surgical Provider Options" on pages 14-15 for specific information.
- Although you can select any approved provider type, network providers offer several advantages:
  - Higher level of coverage.
  - No claim forms for you to fill out.
  - Your enrollee coinsurance applies to your annual medical/surgical out-of-pocket limit.
  - Preventive care, preauthorized hospice services, and tobacco cessation services through *Free & Clear* are covered at 100% of allowed charges.
  - You're not responsible for differences between the provider's billed charge and the UMP allowed charge.
- Because the UMP PPO network includes such a large number of physicians and other health care professionals, it's likely your current provider is already a network provider.
- All care must be medically necessary (as defined on pages 65-66) to be covered.
- Enrolling in the UMP PPO also gives you access to network pharmacies nationwide, where you can purchase retail prescription drugs at discounted rates—with no claim forms to worry about. You may also order prescriptions through our mail-service pharmacy. See pages 15-17 for details on your prescription drug benefits.
- Preventive care, routine vision exams and hardware, and required second opinions are not subject to the annual medical/surgical deductible.

How to Use the Plan

- Review the UMP PPO's online provider and pharmacy directories at **www.ump.hca.wa.gov,** or call UMP Customer Service at 1-800-762-6004 or 425-670-3000 in the Seattle area to request these directories.
- Choose a UMP PPO network provider or UMP network pharmacy. *Provider* can refer to a person (a doctor or other health care professional) or a facility (such as a hospital, clinic, etc.). Since network changes occur daily, when calling for an appointment ask if your provider is a UMP PPO network provider. You may also call UMP to confirm your provider's status. Remember that UMP PPO network providers are covered at a higher benefit level and give you other advantages as well. Network pharmacies offer not only a discounted price but also cap the amount you pay for certain retail prescription drugs. Network

providers and network pharmacies offer you financial protection, because you cannot be billed for the difference between their billed charge and the UMP allowed charge for covered services.

- Identify yourself as a UMP PPO enrollee when you make an appointment with a network provider.
- Present your UMP PPO I.D. card when you receive health care services or have a prescription filled. When UMP PPO is the primary payer (see definition on page 67), the network provider or network pharmacy will submit the claim for you.
- Where there is no access to network providers, receive out-of-network benefits anywhere in the world! Please note that out-of-network providers can bill you for the difference between the UMP allowed charge and the provider's billed charge, in addition to UMP PPO cost-sharing requirements (see page 14).
- You may choose to use a non-network provider whenever you like. If you do, your out-of-pocket expenses are greater, your enrollee coinsurance doesn't apply to your annual medical/surgical out-of-pocket limit, and you may be responsible for submitting your own claims to the UMP for reimbursement. Non-network providers can bill you for the difference between their billed charge and the allowed charge, in addition to UMP PPO cost-sharing requirements (see page 14). Non-network pharmacies also will often cost you more, and you'll need to submit your own claim form.
- Remember that some services and prescription drugs require medical review/preauthorization (see pages 19-20 for details). This discourages unnecessary care, saves money for you and the UMP PPO, and helps ensure the treatment and drugs you receive are necessary and appropriate. Although you're responsible for obtaining medical review/preauthorization and prescription drug review, your network provider or pharmacy may assist you with this process.

Your Rights and Responsibilities as a UMP PPO Enrollee

To ensure UMP PPO offers the best possible medical care, we must work together with you and your providers as partners. To achieve this goal, you must first know your rights and responsibilities.

As a UMP PPO enrollee, you have the right *to:*

- Be treated with respect.
- Be informed by your providers or the UMP about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Have information about:
  - How new technology is evaluated for inclusion as a covered benefit.
  - How providers are reimbursed by the UMP PPO.
  - Preauthorization and review requirements.
  - Providers you select and their qualifications.
  - The UMP and our network of providers.
  - Your covered expenses, exclusions, and maximums/limits.
- Keep your medical records and personal information confidential.
- Obtain a second opinion regarding your provider's care recommendations.
- Make decisions in consultation with your providers about your health care.
- Make recommendations about enrollee rights and responsibilities.
- Have a translator's assistance, if required, when calling UMP.
- Receive:
  - All medically necessary covered services and supplies described in your *Certificate of Coverage*, subject to the maximums/limits, exclusions, deductibles, and enrollee coinsurance/copays.
  - Clear information from your provider about illness or treatment before services and supplies are provided.
  - Courteous, prompt answers from UMP.
  - Timely, proper medical care without discrimination of any kind—regardless of health status or condition, sex, ethnicity, race, marital status, or religion.
  - Written explanation from UMP regarding any request to refund an overpayment.
- Voice complaints or initiate appeals about UMP PPO services, decisions, or the care you receive.

As a UMP PPO enrollee, you have the responsibility *to:*

- Complete and return the annual coordination of benefits questionnaire you receive from the UMP in a timely manner to prevent delay in claims payment.
- Comply with requests for information by the date given.
- Follow your providers' instructions about your health care.
- Give your providers complete information about your health to get the best possible care.
- Keep your providers' phone numbers handy and know how to make or cancel an appointment as well as how to reach your providers after hours.
- Know how to access emergency care.
- Not engage in fraud or abuse in dealing with UMP or your providers.
- Participate with your providers in making decisions about your health care.
- Pay your copayments, coinsurance, or deductibles promptly.
- Refund promptly any overpayment made to you or for you.
- Report to UMP any outside sources of health care coverage or payment as well as any changes in your dependents or in your address.
- Show the same respect to your providers and UMP as you expect from them.
- Understand your UMP PPO benefits, including what's covered, preauthorization and review requirements, and other information described in this *Certificate of Coverage.*
- Use UMP PPO network providers when available to help ensure quality care at the lowest cost.

Disclosure Information

We support the goal of giving you and your family the detailed information you need to make the best possible health care decisions. The following information can be found in this *Certificate of Coverage*:

- List of covered expenses (see pages 22-38).
- Benefit exclusions, reductions, and maximums/limits (see pages 39-42).
- Clear explanation of complaint and appeal procedures (see pages 46-49).
- Preventive health care benefits that are covered (see pages 31-36).
- Definition of terms (see pages 62-68).

The following information is available on the UMP Web site at **www.ump.hca.wa.gov**, or by calling UMP Customer Service at 1-800-762-6004.

- Annual accounting of all payments made by the UMP PPO that have been counted against any payment limits, day limits, visit limits, or other limits on your coverage.
- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services.
- Documents and other materials referred to in PEBB open enrollment materials or this *Certificate of Coverage.*
- General reimbursement or payment arrangements between UMP PPO and network providers.
- How you can be involved in decisions about benefits.
- List of network providers, including both primary care providers and specialists.
- Notice of privacy practices (includes UMP policy for protecting the confidentiality of health information; see page 4).
- Preferred drug list, including policies regarding drug coverage and how drugs are added to or removed from the list.
- Procedures to follow for consulting with providers.
- Process for preauthorization/review.
- Accreditation information, including measures used to report health plan performance such as consumer satisfaction survey results or Health Employer Data Information Set (HEDIS) measures.
- Information on UMP PPO's disease management programs.
- When UMP PPO may retrospectively deny coverage for preauthorized care.

UMP does not prevent or discourage providers from informing you of the care you require, including various treatment options and whether, in the provider's view, that care is consistent with UMP PPO's coverage criteria. You may, at any time, obtain health care outside of UMP PPO coverage for any reason; however, you must pay for those services and supplies. In addition, the UMP does not prevent or discourage you from discussing the merits of different health care insurers with your provider.

Confidentiality of Individually Identifiable Health Information

The UMP abides by our Notice of Privacy Practices, available online at **www.ump.hca.wa.gov/members/planinfo/privacypractices.shtml** or by calling Customer Service at 1-800-762-6004 to request a copy. Enrollee health information will be disclosed only with the consent or authorization of that enrollee or of someone authorized to give consent or authorization on the enrollee's behalf, as required or permitted by law or court order, or as needed to handle claims.

Your Cost-Sharing Requirements

Annual Medical/Surgical Deductible

A deductible is a dollar amount you must pay before the UMP PPO will pay most benefits. The annual medical/surgical deductible is $200 per person and is calculated from January 1 to December 31, even if you're enrolled for only part of the year. For example, a person enrolled in July would still have to pay the entire annual medical/surgical deductible for that year before the plan would reimburse for medical/surgical benefits, then would have to pay a new medical/surgical deductible beginning in January next year.

The maximum annual medical/surgical deductible, payable by all family members combined under one subscriber's account, is $600 (for families of three or more covered persons). When a family's total annual medical/surgical deductible reaches this amount, no further medical/surgical deductible will be required for any family member during that calendar year.

Medical/surgical services are subject to their own annual medical/surgical deductible, and do not apply to the annual prescription drug deductible.

Please note: Charges applied to your annual deductible also count toward any applicable benefit maximum or limit. For example, spinal manipulations have a visit limit of 10 per year. If you pay out-of-pocket for three visits that count toward your annual deductible, those three visits also count toward your 10-visit limit. You would then have seven visits remaining under your UMP PPO coverage for the rest of that year.

Benefits Not Subject to the Annual Medical/Surgical Deductible

The following services are exempt from the annual medical/surgical deductible—they will be paid according to their own reimbursement schedules, even if the annual medical/surgical deductible has not been met:

- Preventive care benefits listed on pages 31-36.
- Required second opinions.
- Routine eye exams and vision hardware.
- Services received under the *Free & Clear* tobacco cessation program.

Annual Prescription Drug Deductible

The annual prescription drug deductible is $100 per person, calculated for prescriptions purchased from retail pharmacies and our mail-service pharmacy from January 1 to December 31. The maximum annual prescription drug deductible, payable by all members of a family combined under one subscriber's account, is $300 (for families of three or more covered persons). Like the annual medical/surgical deductible, you must meet your full annual prescription drug deductible even if you enroll near the end of the year.

Prescription drugs are subject to their own annual prescription drug deductible, and do not apply to the annual medical/surgical deductible.

Coinsurance

Coinsurance is the percent of allowed charges that UMP PPO pays for medically necessary covered services; *enrollee* coinsurance is the percent you're required to pay (when UMP PPO pays less than 100%). See the "Summary of Benefits" charts on pages 7-13 for coinsurance levels.

Copayments

A copayment is a dollar amount you pay when receiving specific services, treatments, or supplies, such as an inpatient hospitalization in a Washington or Oregon network facility, emergency room care, or a prescription filled through our mail-service pharmacy. See the "Summary of Benefits" charts on pages 7-13 for specific copayment requirements.

Annual Medical/Surgical Out-of-Pocket Limit

This out-of-pocket limit refers to the maximum total amount that you may be required to pay for most enrollee coinsurance and copayments each calendar year. Once your eligible enrollee coinsurance and copayment costs reach $1,125 per person or $2,250 per family (all family members combined under one subscriber's account), most medical/surgical claims for covered services from UMP PPO network providers or out-of-network providers (see pages 66-67 for definition) are paid at 100% of allowed charges for the remainder of the calendar year.

After you have reached your annual medical/surgical out-of-pocket limit, you will still be responsible for the difference between your provider's billed charge and the UMP allowed charge for out-of-network services.

The following costs are **not** counted towards your annual medical/surgical out-of-pocket limit:

- Annual medical/surgical and prescription drug deductibles.
- Benefit reductions for failure to comply with medical review/preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.
- Enrollee coinsurance/copayments for retail and our mail-service prescription drugs.
- Enrollee coinsurance/copayments for services from non-network providers.

Non-network providers are covered at 60% of allowed charges regardless of whether or not you have satisfied your out-of-pocket limit. In many cases, a provider's billed charge is higher than the UMP's allowed charge. Your financial responsibility when using non-network providers is the combination of the 40% enrollee coinsurance plus the difference between billed and allowed charges.

Maximum Plan Payment

The total UMP PPO will pay for all benefits is limited to a lifetime maximum of $2,000,000 per enrollee. Up to $10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by the UMP PPO during the prior calendar year. Some services are also subject to specific calendar year or other benefit limits, as detailed in the "Summary of Benefits" starting on page 7.

Summary of Benefits

This section summarizes your UMP PPO benefits. To match our benefit structure, you'll notice that services are separated by those received ***inside*** Washington and Oregon (as well as four border counties of Idaho), and those received ***outside*** Washington and Oregon. The UMP PPO covers only medically necessary services and supplies, as defined on pages 65-66. Please refer to "Covered Expenses" as well as "Expenses Not Covered, Exclusions, and Limitations" for more details.

Please note that UMP PPO has no waiting period for coverage of pre-existing health conditions.

For any UMP PPO benefit, once you have met the cost-sharing requirements, the plan pays at the levels shown on the following summary charts, subject to any benefit maximums or limits indicated. The percent paid by the plan refers to percent of the allowed charge only. The remaining amount of the allowed charge is your enrollee coinsurance (defined on page 63).

Only the *allowed charge* is covered—the maximum payment the plan allows for a specific service or supply (see definition on page 62). In many cases, the UMP's allowed charge is less than the provider's billed charge for the service. If you use non-network or out-of-network providers, you will also be responsible for the difference between the provider's billed charge and the UMP allowed charge for the particular service (that is, in addition to UMP PPO cost-sharing requirements). *Network* providers have agreed to accept the UMP allowed charge as payment in full; *out-of-network* and *non-network* providers have not. See pages 14-15 for more information on your provider options.

In most circumstances, UMP PPO follows Medicare policy related to claims payment policies and procedures.

Some services also have specific limits, as shown in the summary charts.

The following sections describe your UMP PPO benefits along with other details you'll need to use the plan effectively. If you have questions, see the Directory (inside the front cover) for contact information.

Summary of Benefits

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is often less than the provider's billed charge.**

Benefits	Plan payment for network providers INSIDE WA/OR & Idaho counties[1]	Plan payment for network providers OUTSIDE WA/OR & Idaho counties[1]	Plan payment** for non-network providers	Preauthorization required?	See page***
Acupuncture 16 treatments max/year	90%	80%	60%	No	22, 39
Ambulance Air and ground	80%	80%	80%	No	22, 39
Biofeedback (if for mental health diagnosis: see Mental Health benefits)	90%	80%	60%	No	22, 27
Blood and Blood Derivatives	90%	80%	60%	No, except stem cell harvesting for transplant purposes	23, 39
Bone, Eye, and Skin Bank Services	90%	80%	60%	No	23
Cardiac and Pulmonary Rehabilitation	90%	80%	60%	Yes	20, 23
Chemical Dependency Treatment $12,500 maximum plan payment per consecutive 24 calendar month period for inpatient and outpatient combined (excludes detox if you haven't been admitted to a chemical dependency program when receiving those services)					23, 39, 63
• **Inpatient**	100% after $200 copay/day; $600 max copay/person/year	80%	60%	No	
• **Outpatient**	90%	80%	60%	No	
Dental Services (limited – does not include routine dental care, or most common dental services)	90%	80%	60%	No, except surgical treatment of TMJ	23, 39
Diabetes Education	90%	80%	60%	No	24, 40

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

[1] Refers to the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Benefits	Plan payment for network providers INSIDE WA/OR & Idaho counties[1]	Plan payment for network providers OUTSIDE WA/OR & Idaho counties[1]	Plan payment** for non-network providers	Preauthorization required?	See page***
Diagnostic Tests, Laboratory, and X-Rays (outpatient)	90%	80%	60%	Certain services	24, 40
Dialysis	90%	80%	60%	No	24
Durable Medical Equipment, Supplies, and Protheses ***Note:*** For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, $100 lifetime max	90%	80%	60%	Yes, for rentals over 3 months and purchases over $1,000	24-25, 40, 63
Emergency Room (ER) ER copay waived if admitted directly from ER; copay does not count toward the annual medical/surgical deductible or medical/surgical out-of-pocket limit	90% after $75** copay/visit	80% after $75** copay/visit	80% after $75** copay/visit	No	25, 65
Hearing Care $400 max/36 months applies to routine hearing exam, hearing aid, and rental/repair combined	90%	80%	60%	No	25, 40
Home Health Care	90%	80%	60%	Yes	25-26, 40, 64
Hospice Care					26, 40, 42,
• **Inpatient**					64-65
When preauthorized	100%	100%	60%	Yes	
When NOT preauthorized	90%	80%	60%	No	
• **Respite Care** ($5,000 lifetime max)	100%	100%	60%	Yes	
Hospital Services					
• **Inpatient**					26, 41
Facility charges	100% after $200 copay/day; $600 max copay/person/year	80%	60%	No; see "Physical, Occupational, Speech, and Massage Therapy" for exceptions.	
Professional services	90%	80%	60%	No	
• **Outpatient**	90%	80%	60%	No	26

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* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

[1] Refers to the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce.

Summary of Benefits, continued

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is often less than the provider's billed charge.**

Benefits	Plan payment for network providers INSIDE WA/OR & Idaho counties[1]	Plan payment for network providers OUTSIDE WA/OR & Idaho counties[1]	Plan payment** for non-network providers	Preauthorization required?	See page***
Mammograms					
• **Screening mammograms*** (beginning at age 40, every one or two years)	100%	100%	60%	No	24, 36
• **Diagnostic mammograms**	90%	80%	60%	No	24
Mastectomy and Related Services	90%	80%	60%	No	26-27
Mental Health Treatment					27, 41,
• **Inpatient:** 10 days max/year	100% after $200 copay/day; $600 max copay/person/year	80%	60%	No, except for partial hospitalization services	42
• **Outpatient:** 20 visits max/year	90%	80%	60%	No	
Naturopathic Physician Services	90%	80%	60%	No	27, 40
Neurodevelopmental Therapy (Ages 6 years and under)					27-28, 41
• **Inpatient:** 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	80%	60%	No	
• **Outpatient:** 60 visits max/year for all therapies combined	90%	80%	60%	No, but treatment plan required	
Obstetric and Newborn Care					28
• **Inpatient**					
Facility charges	100% after $200 copay/day; $600 max copay/person/year (Routine newborn nursery care is not subject to copay)	80%	60%	No	
Professional services	90%	80%	60%	No	
• **Outpatient**	90%	80%	60%	No	

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

[1] Refers to the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Benefits	Plan payment for network providers INSIDE WA/OR & Idaho counties[1]	Plan payment for network providers OUTSIDE WA/OR & Idaho counties[1]	Plan payment** for non-network providers	Preauthorization required?	See page***
Office, Clinic, and Hospital Visits	90%	80%	60%	No	28, 39, 41
Organ Transplants					28-29, 41
• **Inpatient**					
Facility charges	100% after $200 copay/day; $600 max copay/person/year	80%	60%	Yes	
Professional services	90%	80%	60%	Yes	
• **Outpatient** Donor search (bone marrow, stem cell, umbilical cord) is limited to 15 searches per transplant	90%	80%	60%	Yes	
Out-of-Network Care (includes care obtained in locations without access to network providers, as well as in Oregon State and Idaho counties of Bonner, Kootenai, Latah, and Nez Perce)	Not applicable	Not applicable	80%	Varies by service/ supply	15, 67
Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)	90%	80%	60%	No	29, 42
Phenylkentonuria (PKU) Supplements	90%	80%	60%	No	29
Physical, Occupational, Speech, and Massage Therapy					29-30, 41
• **Inpatient:** 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	80%	60%	Yes	
• **Outpatient:** 60 visits max/year	90%	80%	60% (massage therapists not covered)	No, but treatment plan required	

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* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

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[1] Refers to the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce.

Summary of Benefits, continued

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is often less than the provider's billed charge.**

Benefits	Plan payment for network providers INSIDE WA/OR & Idaho counties[1]	Plan payment for network providers OUTSIDE WA/OR & Idaho counties[1]	Plan payment** for non-network providers	Preauthorization required?	See page***
Prescription Drugs* (up to a 90-day supply)					15-17, 30-31, 39, 40, 41, 42
• **Retail pharmacies****: Annual prescription drug deductible applies. After you meet your annual prescription drug deductible, your cost-share limit for Tier 1 and Tier 2 drugs is: $50 per prescription for up to 30 days' supply, $100 per prescription for 31-60 days' supply, and $150 per prescription for 61-90 days' supply. Limit does not apply to Tier 3 drugs and prescriptions purchased at non-network pharmacies.					
Tier 1: Generic drugs, all insulin and all disposable diabetic supplies	80% (enrollee coinsurance is 20% or cost-share limit, whichever is less)	80% (enrollee coinsurance is 20% or cost-share limit, whichever is less)	80%	Certain drugs	
Tier 2: Preferred brand-name drugs	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70%	Certain drugs	
Tier 3: Nonpreferred brand-name drugs	50%	50%	50%	Certain drugs	
• **Mail-service pharmacy****: Annual prescription drug deductible applies. If the actual price of the medication is less than the standard copay, you pay a minimum charge of $8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.					
Tier 1: Generic drugs, all insulin, and all disposable diabetic supplies	100% after $10 copay/refill	100% after $10 copay/refill	Not covered	Certain drugs	
Tier 2: Preferred brand-name drugs	100% after $40 copay/refill	100% after $40 copay/refill	Not covered	Certain drugs	
Tier 3: Nonpreferred brand-name drugs	100% after $80 copay/refill	100% after $80 copay/refill	Not covered	Certain drugs	

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

[1] Refers to the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Benefits	Plan payment for network providers INSIDE WA/OR & Idaho counties[1]	Plan payment for network providers OUTSIDE WA/OR & Idaho counties[1]	Plan payment** for non-network providers	Preauthorization required?	See page***
Preventive Care* See specific services covered	100%	100%	60%	No	31-36, 39
Radiation and Chemotherapy	90%	80%	60%	No	37
Second Opinions					20, 37
• **When required by UMP***	100%	100%	100%	No	
• **When optional**	90%	80%	60%	No	
Skilled Nursing Facility 150 days max/year	100% after $200 copay/day; $600 max copay/person/year	80%	60%	Yes	37, 41, 42
Special Nursing Services $5,000 max/year	90%	80%	60%	No	37
Spinal and Extremity Manipulations 10 visits max/year	90%	80%	60%	No	37, 41
Temporomandibular Joint (TMJ) Treatment (surgical)	90%	80%	60%	Yes	20, 37
Tobacco Cessation Program* *Free & Clear* program only	100%	100%	Not covered	No	30, 38, 41, 42
Vision Care*					38, 41, 42
• **Eye exams** (routine)—Once every two calendar years	90%	80%	60%	No	
• **Vision hardware—**Including frames, lenses, contact lenses, and fitting fees combined	$100 max plan payment every two calendar years	$100 max plan payment every two calendar years	$100 max plan payment every two calendar years	No	
Well-Baby Preventive Care Services* See specific services covered under "Preventive Care"	100%	100%	60%	No	32-34, 39

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

[1] Refers to the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

How the UMP PPO Works

While you may receive coverage for services performed by any approved provider type (see list on pages 18-19), your out-of-pocket expenses will be less if you use a UMP PPO network provider or network pharmacy. You'll be responsible only for any deductibles, enrollee coinsurance, and copayment along with expenses not covered (see the section starting on page 39), and charges that exceed benefit maximums/limits.

If you use an out-of-network provider or a non-network provider or pharmacy, you'll also be responsible for amounts that exceed the UMP allowed charge (defined on page 62), in addition to your cost-sharing requirements and any expenses not covered.

When UMP PPO is the primary payer (see definition on page 67 and "If You Have Other Medical Coverage" on pages 50-51), network providers and network pharmacies will submit your claims and call to request any required medical review/preauthorization, saving you money on your share of the bill. If you use an out-of-network provider or a non-network provider or pharmacy, you'll be responsible for obtaining any required medical review/preauthorization, and you may have to pay for services and submit a claim form before you receive reimbursement from the UMP PPO.

You and each covered dependent may choose different providers and decide whether to use UMP PPO network providers and network pharmacies.

Your Medical/Surgical Provider Options

Medical/surgical provider options are described below:

Network Providers

Refers to providers who have contracted directly with UMP (or are part of a network that has contracted with UMP) to render services to UMP PPO enrollees at a reduced rate. Network providers agree to accept the UMP allowed charge as payment in full for services covered by UMP PPO. They cannot bill you for the difference between their billed charge and the UMP allowed charge. And using a network provider means you don't have to file claims. **Exception:** For services not covered by UMP PPO, network providers can bill their usual and customary charge.

For care in Washington, UMP directly contracts with a provider network that includes most acute care hospitals, nearly every major multispecialty clinic in the state, more than 9,200 physicians, and over 7,700 nonphysician health care professionals such as advanced registered nurse practitioners and physical, occupational, and speech therapists. We include additional alternative care providers (naturopaths, acupuncturists, and massage therapists) as network providers through an arrangement with the Alternáre network.

For care in the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce—UMP has some direct contracts with network providers. Other providers in these counties are considered out-of-network providers (see definition on page 67), since the UMP PPO network does not provide access to a full range of health care services.

For care elsewhere in the United States (other than Washington, and the four Idaho counties identified above)—Access to network providers is through the Beech Street network, unless Medicare is your primary coverage. The Beech Street network is not available to Medicare enrollees, except in Oregon, because UMP coordination of benefits with Medicare covers most services in full (up to the Medicare allowed charge), regardless of network affiliation.

See the summary tables starting on page 7 for the cost-sharing requirements that apply to services you receive from network providers. Your enrollee coinsurance (10% or 20%) for care from a network provider *does* apply to your annual medical/surgical out-of-pocket limit once your annual medical/surgical deductible has been met.

Preventive care and preauthorized hospice services are covered at 100% of allowed charges when you use network providers.

To locate a network provider in Washington State, you may use the online provider directory on the UMP Web site at **www.ump.hca.wa.gov**, or call UMP Customer Service at 1-800-762-6004 or 425-670-3000 in the Seattle area. You may also get a printed copy of the directory from Customer Service. However, please note that you will receive the most up-to-date information by calling Customer Service, as provider status may change after the directory is printed.

For information on the Beech Street network:

Phone: 1-800-432-1776
Web site: www.beechstreet.com

Please be sure to use the Beech Street network directory only for care outside Washington and the four Idaho counties named above. While Beech Street has arrangements with providers in Washington and the four Idaho counties, these providers are not necessarily UMP PPO network providers.

Out-of-Network Providers

Refers to providers practicing in U.S. locations where there is no access to network providers as well as to all providers outside the U.S. (see definition of Service Area on page 68). In Oregon and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce, any provider who does not contract with UMP, Beech Street, or Alternáre is considered an *out-of-network* provider.

UMP PPO's reimbursement rate is 80% of allowed charges, after your annual medical/surgical deductible has been met. Out-of-network providers can bill you for the difference between their billed charge and the UMP allowed charge (see definition on page 62). Your enrollee coinsurance (20%) for care from an out-of-network provider *does* apply to your annual medical/surgical out-of-pocket limit.

Out-of-network, nonemergency services outside the U.S. must meet the UMP criteria explained under "Services Received Outside the U.S." on page 19.

Non-Network Providers

Refers to providers practicing in locations with access to network providers, but not contracted as a network provider. (In other words, these providers are in areas where you could choose a network provider, but decide not to.) See the exception above regarding Oregon and the four Idaho counties.

Non-network providers can bill you for the difference between their billed charge and the allowed charge.

UMP PPO's reimbursement rate is 60% of allowed charges after your annual medical/surgical deductible has been met.

Your enrollee coinsurance (40%) for care from a non-network provider does **not** apply to your annual medical/surgical out-of-pocket limit.

Your Prescription Drug Provider Options

Although the prescription drug benefit differs based on whether drugs are purchased at a network or non-network pharmacy, it does not differ based on geographic location. In addition to network and non-network retail pharmacies, you also have the choice of filling your prescriptions through our mail-service pharmacy. In most cases, you may receive up to a 90-day supply of medication, as prescribed by your physician, through either a retail or our mail-service pharmacy.

Retail Pharmacies

The UMP contracts with network pharmacies through Express Scripts, Inc. Network pharmacies are available nationwide, and have agreed to provide prescription drugs at a discounted rate. Although you may use any pharmacy, a UMP network pharmacy will save you time and money by collecting only your annual prescription drug deductible and applicable enrollee coinsurance at the point of sale, and filing your claims for you. In addition, by using network pharmacies, you'll have the advantage of a cost-share limit on Tier 1 and Tier 2 drugs (see page 17).

At non-network pharmacies, you won't receive a discounted rate; the Tier 1 and Tier 2 cost-share limit doesn't apply; and you're required to pay the full cost of the prescription at the pharmacy, submit the claim to UMP, and wait for reimbursement.

Transferring to a network pharmacy is easy. Just contact the network pharmacy of your choice, tell them you are a UMP PPO enrollee and would like them to transfer your prescriptions from your current pharmacy. Be ready with the name and phone number of your current pharmacy as well as the prescription numbers or drug names and dosages. The UMP network pharmacy will do all the work.

At network and non-network retail pharmacies, you pay a coinsurance based on a percentage of the allowed charge for the prescription. If you purchase a prescription at a non-network pharmacy and the amount charged by the pharmacy is higher than the UMP allowed amount, you are responsible for the cost difference. The enrollee coinsurance varies according to the drug "tier" as described in the chart on page 17.

The UMP does not recognize or contract with other Internet or mail-service pharmacies—only the Express Scripts, Inc. mail-service pharmacy.

Mail-Service Pharmacy

The UMP PPO also offers prescription drugs through our network mail-service pharmacy. After you meet the annual prescription drug deductible, you pay a fixed dollar copayment per prescription or refill, based on the applicable drug "tier" as described in the chart on page 17. To order a prescription or refill by mail, you may visit the UMP Web site at **www.ump.hca.wa.gov**, or call Express Scripts Member Services at 1-866-576-3862.

Your Prescription Drug Benefit Amount

See "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" on pages 30-31 for details on both the retail and mail-service pharmacy benefits.

The amount you pay for a prescription is determined by the tier level the drug falls in (see table on page 17). The UMP Preferred Drug List (PDL) is a list of prescription drugs that have been identified as providing safe, cost-effective treatment. Generic drugs have the same active ingredient as their brand name counterparts and are usually less expensive. Using generic and preferred drugs reduces costs both for you and for UMP. You may still choose nonpreferred drugs but you will generally pay more if you do.

UMP Preferred Drug List

The UMP PDL includes drugs from the Washington Preferred Drug List (Washington PDL) and Express Scripts' National Formulary. Development and maintenance of the UMP PDL is a dynamic process. The Washington PDL is based on recommendations by the Washington Pharmacy & Therapeutics Committee (P&T Committee), an independent group of practicing health care providers that meets quarterly to help ensure that the content is medically sound and supportive of your health. It is updated periodically as new information and drugs become available. Once these reviews are completed, the UMP PDL may change based on the P&T Committee's recommendations. UMP uses the Express Scripts' National Formulary for drug classes not yet reviewed by the P&T Committee.

UMP retains the right to update the UMP PDL or shift medications to different tiers during the year if generic or over-the-counter alternatives become available, or if there are changes to the Washington PDL or Express Scripts' National Formulary. UMP will notify enrollees of changes made to the UMP PDL or Drug Coverage Management programs if these occur during the plan year.

Limits on Specialty Drugs

Specialty drugs as listed on the UMP PDL are limited to a 30-day supply at your retail pharmacy. Up to a 90-day supply (as ordered by your prescribing physician) is available through UMP's mail-service pharmacy.

Prescription Drug Benefits Summary

After you have met your annual prescription drug deductible, your cost-share for a prescription or refill is:

Tier	Enrollee's cost at a network retail pharmacy (for up to a 90-day supply per prescription or refill)	Enrollee's cost using mail-service pharmacy (for up to a 90-day supply per prescription or refill)
Tier 1 Generic drugs, all insulin, and all disposable diabetic supplies	Lesser of 20% coinsurance or maximum enrollee cost-share limit (see below*)	$10 copay (see below**)
Tier 2 Preferred brand-name drugs cost-share limit (see below*)	Lesser of 30% coinsurance or maximum enrollee	$40 copay (see below**)
Tier 3 Nonpreferred brand-name drugs share limit does not apply	50% coinsurance Maximum enrollee cost-	$80 copay (see below**)

* ***Enrollee cost-share limit:*** *For up to a 30-day supply, the limit is $50. For a 31- to 60-day supply, the limit is $100. For a 61- to 90-day supply, the limit is $150. The maximum enrollee cost-share limit does not apply to Tier 3 drugs or drugs purchased at a non-network pharmacy.*

** *If the actual price of the medication is less than the standard copay, you pay a minimum charge of $8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.*

Enrollees who use the network mail-service pharmacy have the additional convenience of requesting refills online by accessing Express Scripts' Web site through the UMP Web site at **www.ump.hca.wa.gov**.

Although in most cases you can receive up to a 90-day supply of your prescription drug, the actual supply depends on the provider prescribing the medication. If your provider orders less than a 90-day supply, the pharmacist cannot give you more. At mail-service, if your prescription is for less than a 90-day supply, your copayment will not be prorated.

To find out which drugs are listed as preferred:

- Review the UMP *Guide to Preferred Drugs*;
- Visit the UMP Web site at **www.ump.hca.wa.gov** and link to the UMP Preferred Drug List; or
- Call Express Scripts, Inc. at 1-866-576-3862.

See "Covered Expenses" starting on page 22 and "Summary of Benefits" on pages 7-13 for more information on your prescription drug benefit.

Approved Provider Types

Only services performed by approved provider types are covered under the UMP PPO. The list of approved provider types below includes individual medical professionals, hospitals and other facilities or organizations, pharmacies, and programs.

To bill the UMP directly and receive payment in accordance with UMP PPO benefits, the provider must:

- Be of a type appearing on the approved provider list;
- Have a current license, registration, or certificate to deliver services at their location;
- Perform only services within the provider's scope of practice, as defined by the licensing agency; and
- Provide services within the UMP PPO's benefit limits.

"Approved" does not indicate whether a provider is network, out-of-network, or non-network.

Approved provider types include:

- Acupuncturists, licensed (LAc).
- Alcohol/Chemical Dependency Centers and Substance Abuse Treatment Facilities, licensed with Department of Social and Health Services (DSHS) certification (must be approved by the UMP); non-PhD psychologists and mental health counselors employed by these facilities are covered only when delivering services within an approved substance abuse facility *and* the facility bills for their services.
- Ambulatory Surgical Centers (ASC), licensed (Medicare-certified or JCAHO or other recognized national accreditation).
- Audiologists, certified.
- Biofeedback technicans, certified; covered only when employed by and delivering services within a hospital or other UMP-approved facility *and* the employing organization bills for their services.
- Birthing centers, licensed.
- Chiropractors, licensed (Doctors of Chiropractic [DC]).
- Community mental health agencies, licensed; non-PhD psychologists and counselors employed by these agencies are covered only when employed by and delivering services within a licensed community mental health agency *and* the agency bills for their services.
- Counselors, licensed, including Licensed Marriage and Family Therapists (LMFT), Licensed Masters of Social Work (LMSW), and Licensed Mental Health Counselors (LMHC).
- Dentists, licensed (Doctors of Dental Medicine [DMD] and Doctors of Dental Surgery or Dental Science [DDS]) (see page 23 for limits on dental services covered).
- Diabetes education programs (including Medical Nutrition Therapy), Medicare-approved or otherwise approved by UMP.
- *Free & Clear* tobacco cessation program.
- Hearing aid fitters and dispensers, licensed.
- Home health aides, licensed (covered only when employed by and delivering services within a hospice or home health agency *and* that agency bills for their services).
- Home health or hospice agencies, licensed (Medicare-certified or JCAHO-accredited).
- Hospitals, licensed.
- Massage practitioners, licensed (LMP); only massage practitioners accepted into the UMP provider network are considered approved providers.
- Medical nutrition therapists (MNT), Medicare-approved or otherwise approved by UMP for the treatment of diabetes mellitus (see Diabetes education programs) or chronic renal insufficiency, end-stage renal disease when dialysis is not received, or medical conditions up to 36 months after kidney transplant. MNTs are covered only when employed by and delivering services within a hospital or other UMP-approved facility *and* the employing organization bills for their services.
- Midwife, licensed (LM).
- Naturopaths, licensed (Naturopathic Doctors [ND]).
- Nurses, licensed including Licensed Advanced Registered Nurse Practitioners (ARNP) and Licensed Certified Nurse Midwives (CNM) (all types must be licensed); see Practical Nurses, Registered Nurses, and Registered Nurse First Assistants.
- Occupational therapists, licensed (OT).
- Optometrists, licensed (Doctors of Optometry [OD]).
- Pharmacists, licensed and registered (RPh) or Doctors of Pharmacy (PharmD).
- Pharmacies, licensed.
- Physical therapists, registered and licensed (RPT).
- Physicians, licensed (Doctors of Medicine [MD], or Doctors of Osteopathic Medicine [DO]).
- Physician Assistants, licensed (PA) (covered only when providing services under the supervision of a

clinician *and* the clinician who is supervising bills for their services).

- Podiatrists, licensed (Doctors of Podiatric Medicine [DPM]).
- Practical Nurses, licensed (LPN) (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Psychologists, licensed (PhD).
- Registered Nurses, licensed (RN) (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Registered Nurse First Assistants, certified and licensed (covered only when providing services under the supervision of a clinician *and* the clinician who is supervising bills for their services; only *Certified* Registered Nurse First Assistants are covered).
- Respiratory therapists, licensed (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Skilled nursing facilities, licensed (Medicare-certified).
- Speech pathologists, licensed and certified by the American Speech, Language and Hearing Association.

Services Received Outside the U.S.

Health care services may be covered outside of the U.S. as long as they:

- Are provided by an approved provider type;
- Are medically necessary (see definition on pages 65-66);
- Are appropriate for the condition being treated;
- Are not considered to be experimental or investigational by United States standards; and
- Would otherwise be covered by the UMP PPO.

These services are generally covered at the out-of-network benefit level once the annual medical/surgical deductible has been satisfied.

If you are seeking nonemergency services abroad, UMP Medical Review staff can help you determine whether these services will be covered.

Foreign claims and any requested medical records must be translated into English with specific services, charges, drugs and dosage documented, along with the currency exchange rate.

Emergency Care

In cases of accidental injury or medical emergency, call 911 or seek care immediately. If a UMP network facility or provider is not available, you should obtain services from the most conveniently available approved provider. See the "Summary of Benefits" charts for coverage details.

Medical Review/ Preauthorization Requirements

The UMP PPO includes a program to review and approve some medical services and supplies before, during, and after they're received. We have a medical review team to determine the appropriate treatment setting, whether the service or supply is medically necessary, if the service or supply has been accurately billed, and whether it is considered excessive. (The fact a service or supply is prescribed or furnished by an approved provider does not, by itself, make it medically necessary; see definition on pages 65-66).

This program discourages unnecessary care, saves money for you and the UMP, and helps ensure treatment is consistent with standards of good medical practice. Remember, you and your provider always make the final decision to proceed with, postpone, or cancel any admission, treatment, supply, or procedure.

All claims for hospital admissions are subject to retrospective review for medical necessity. Medical reviewers may approve a proposed admission, deny it and suggest alternative methods, or require a second opinion from another specialist.

The following services must be preauthorized by the UMP. Failure to obtain preauthorization prior to service may result in denial of your claim. To ensure you receive UMP PPO benefits, call 1-800-762-6004 or 425-670-3000 in the Seattle area for preauthorization *before* receiving these services. Preauthorization requests may be faxed directly to the Medical Review Department at 425-670-3197.

- *Durable medical equipment, supplies, and prostheses*: Preauthorization is required for rentals beyond three

months or for purchases over $1,000. The UMP will not pay for any additional costs determined non-covered, such as more costly equipment that serves the same medical purpose (for example, an electric wheelchair instead of a manual wheelchair).

It also may be to your benefit to request preauthorization on some frequently prescribed durable medical equipment (such as light boxes, hospital beds, and breast pumps). This helps us address potential coverage issues in advance.

- *Home health care:* Preauthorization is required for cases in which:
  - Visits are daily;
  - Visits are expected to exceed two hours a day; or
  - Length of treatment is expected to last more than three weeks.

  Reauthorization is required every two weeks unless determined otherwise by Medical Review. Call 1-888-759-4855 before starting home health services; otherwise, your claim will be denied if services are later determined not medically necessary or other home health care requirements are not met.
- *Hospice care, including respite care:* Hospice care from UMP PPO network providers is covered in full for up to six months when preauthorized. Respite care has a $5,000 lifetime maximum limit.
- *Organ transplants:* All organ transplants (including bone marrow, umbilical cord, and stem cell transplants) require preauthorization. You also must be accepted into the treating facility's transplant program and follow the program's protocol.
- *Specialty drugs* on the UMP Preferred Drug List that are not normally considered to be self-injectable (when obtained through a retail pharmacy or UMP's mail-service pharmacy).

Other services requiring preauthorization:

- Cardiac/pulmonary rehabilitation.
- Cochlear implants.
- Genetic testing (genetic testing unrelated to pregnancy is covered only when preauthorized and performed by a specialist center/provider designated by the UMP).
- Inpatient admissions for rehabilitation (physical, occupational, speech, and massage therapy).
- Massage therapy in excess of one hour per treatment.
- Mental health partial hospitalization services.
- Positron Emission Tomography (PET) scans.
- Skilled nursing facility admissions.
- Temporomandibular joint (TMJ) surgery.

"Summary of Benefits," "Covered Expenses," and "Expenses Not Covered, Exclusions, and Limitations" contain more information on all services and supplies that require preauthorization.

Obtaining an Estimate of Plan Benefits

Although only the services described in the previous section require preauthorization, you may want to confirm that the treatment you're considering is covered under the UMP PPO, is medically necessary, and will be paid at a certain level.

To obtain an estimate of plan benefits, call the UMP. An estimate is not a guarantee of benefits; the actual benefits are determined when you submit a claim, based on specific services received.

Second Opinions

The UMP's medical reviewers may require a second opinion before approving an admission or procedure. In this case, the second opinion will be paid at 100% of the allowed charge (for network, out-of-network, or in some cases non-network providers) and will not be subject to the annual deductible requirement. If you don't obtain a required second opinion, your benefits may be reduced by up to $200 or denied.

Optional Case Management

The UMP offers an optional case management service at no cost for medical/surgical cases involving complex treatment or high expenses. These cases may be identified during the prenotification process, where hospitals notify the UMP if you are admitted for a diagnosis that may require case management services. Optional case management services are performed under an agreement you and UMP enter before the case management begins.

Required Case Management

To promote quality health care, the UMP medical director may in some cases review medical records and determine that your use of certain services is potentially harmful, excessive, or medically inappropriate. Based on this determination, UMP may require you to participate in and comply with a case management plan as a

condition of continued benefit payment. Case management may include designating a primary physician (MD or DO) to coordinate care, and designating a single hospital and pharmacy to provide covered services or medications. UMP has the right to deny payment for any services received outside of the required case management plan, except medically necessary emergency services.

You have the right to appeal the medical director's determination and the required case management plan through the process outlined under "Complaint and Appeal Procedures" starting on page 46.

Medical Review During Claim Processing

When claims are processed, UMP will verify that treatment was medically necessary and will review provider charges. This may require the submission of medical records. UMP reserves the right of final determination in the amount payable for any service or supply.

Drug Coverage Management

Some medications are covered by UMP PPO only for certain uses or in certain quantities. For example, since UMP PPO excludes cosmetic services and supplies, a drug will not be covered if used solely for cosmetic purposes meant to enhance physical appearance. Also, drug quantity may be limited to specific amounts over certain periods. In these cases, your doctor may need to provide more information to ensure coverage conditions are met.

UMP PPO may limit drugs to specific circumstances and protocols, or restrict initial and/or refill quantities where there is:

- Use outside the scope of this benefit;
- A sound clinical basis;
- Inadequate evidence of cost-effectiveness; or
- Evidence that cost-effectiveness is lacking.

Certain prescription drugs are subject to quantity limits, as indicated on the UMP Preferred Drug List. For some of these drugs, you may request an exception by having your pharmacist or prescribing provider call Express Scripts at 1-800-417-8164. This review is usually completed while your pharmacist or provider is on the phone with Express Scripts. If you're not satisfied with the review decision, you may appeal (see "Complaint and Appeal Procedures" starting on page 46).

Certain drugs in the categories listed below also may require a coverage review process for preauthorization. Check carefully whether the process applies to you or a family member by reviewing the specific criteria used to determine when coverage review is required. Note also that drug categories may be added or removed from this list throughout the year.

- *Growth hormone treatments*: Coverage may be allowed for 3- to 12-month renewable periods following authorization through the review process. Pediatric or adult hormone deficiency and AIDS wasting syndrome are covered conditions.
- *Acne treatment*: Patients ages 10-30 do not have to go through the review process; all others do.

To find out whether a certain drug is subject to review or quantity limits, or for specific questions on drug coverage management procedures or criteria, call Express Scripts at 1-866-576-3862, or visit the UMP Web site at **www.ump.hca.wa.gov**.

For preauthorization of injectable drugs that are not normally approved for self-administration, please call the UMP claims office at 1-800-762-6004.

What to Do if Coverage Is Denied

If a network pharmacy (including mail-service) informs you that coverage is denied or limited, or the prescription is otherwise not covered in full, your pharmacist or prescribing provider may contact Express Scripts at 1-800-417-8164 to begin the prescription drug coverage review process. A written determination will be sent to you and your provider within approximately two business days after your doctor has contacted Express Scripts with the information required to complete the coverage review.

If the medication is needed immediately, you may be eligible to receive a temporary supply during the review process. Ask your pharmacist to contact Express Scripts at 1-800-417-8164 for approval of a temporary supply.

See "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" on pages 30-31 and "Complaint and Appeal Procedures" starting on page 46 for additional information and procedures related to prescription drug coverage.

Covered Expenses

UMP PPO benefits are payable only for medically necessary services and supplies provided in accordance with applicable medical review/preauthorization requirements, except for emergency care or as described for coordination of benefits with other health plans. (See "If You Have Other Medical Coverage" on pages 50-51.) Services must be received from a UMP approved provider type (see list on pages 18-19). In most circumstances, the UMP follows Medicare coverage guidelines. All benefits are subject to the exclusions and limits shown in "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations" as well as in this section. Be sure to check "Definitions" for a description of most terms used in this *Certificate of Coverage*.

Although the UMP PPO strives to provide a full provider network in each geographic region, the fact services or supplies are listed does not necessarily mean network providers are available. Hospital-based physicians (such as anesthesiologists, radiologists, pathologists, emergency room doctors, etc.) typically contract independently from the hospital. This means that if you choose a UMP network hospital, it is important to check that these providers are also UMP network providers. Some of these provider types choose not to contract with health insurance plans.

Most services are subject to the annual medical/surgical deductible. For details on the deductible and the annual medical/surgical out-of-pocket limit, as well as enrollee coinsurance and other cost-sharing, see "How the UMP PPO Works" and "Your Cost-Sharing Requirements."

As described in the "Summary of Benefits" charts and "How the UMP PPO Works," your level of coverage depends on the provider you use and where you receive care.

Except when coverage is required by law, you will be liable for the costs of any services or supplies received after your UMP PPO coverage ends.

The list of UMP PPO covered expenses follows:

Acupuncture

This benefit covers acupuncture treatments or office visits to obtain acupuncture up to a combined total of 16 per calendar year. Acupuncture is covered only when used as an anesthetic or to reduce pain (not instead of surgery).

Ambulance

This benefit covers ambulance services for a life-threatening illness or injury, when other transport is not appropriate, to go:

- From the site of the medical emergency to the nearest facility equipped to treat the life-threatening illness or injury. See definition of medical emergency on page 65;
- From one facility to the nearest other facility equipped to give further treatment; or
- Home (if determined medically necessary).

Charges for regularly scheduled passenger air and rail transportation from the site of the medical emergency to the nearest facility equipped to provide the treatment are covered for the patient only—for one round trip per calendar year.

Ambulance services are reimbursed at 80% of the UMP allowed charge.

If ground ambulance services are not appropriate for transporting to the nearest facility, emergency air ambulance will be covered if the service meets the definition of medical emergency (page 65) and if air ambulance is the only appropriate method of transportation, based solely on UMP's determination of medical necessity.

If you frequently travel outside the U.S., you may want to purchase individual insurance for air ambulance services, as the UMP PPO covers this transportation only to the nearest facility equipped to provide the treatment needed. The fact you or your doctor prefer that you be transported to the facility nearest your home is not a consideration.

Biofeedback Therapy

If used to treat a physical medical condition, such as hypertension (high blood pressure), biofeedback therapy is covered at normal plan payment levels. If used for mental health treatment, biofeedback therapy is covered under the mental health payment provisions and subject to annual visit limits.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Blood and Blood Derivatives

Blood and blood derivatives, including but not limited to synthetic factors, plasma expanders, and their administration, are covered.

Bone, Eye, and Skin Bank Services

Biologic materials supplied by human bone banks, eye banks, and skin banks are covered.

Cardiac and Pulmonary Rehabilitation

Cardiac and pulmonary rehabilitation that meet Medicare guidelines (not maintenance care) are covered when preauthorized.

Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services, up to a maximum plan payment of $12,500 every 24 consecutive calendar month period. Chemical dependency is defined as an illness characterized by a physiological or psychological dependency on a controlled substance or on alcoholic beverages. For purposes of this benefit, treatment and services are medically necessary if recommended in the "Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II" as published in 2001 by the American Society of Addiction Medicine. Chemical dependency does not include dependence on tobacco, caffeine, or food. Covered expenses include:

- Inpatient prescription drugs prescribed in connection with chemical dependency treatment (all other prescription drug charges are paid according to the provisions under "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies," starting on page 30).
- Inpatient treatment according to a prescribed provider plan at a hospital or substance abuse treatment facility, subject to approval by the UMP's medical review program.
- Outpatient substance abuse diagnosis and treatment.

If you are not yet enrolled in a formal chemical dependency treatment program, medically necessary detoxification is covered as a medical emergency and is not included in calculating the dollar maximum chemical dependency treatment benefit.

Dental Services

Routine and most other common dental services, including but not limited to dental extractions and aveoloplasties (regardless of the cause), are not covered as a UMP PPO benefit. However, they may be covered by your PEBB dental plan. See excluded dental services on page 39.

General anesthesia and related facility charges are covered by UMP PPO for any dental procedure performed in a hospital or ambulatory surgical center if the services are medically necessary because the enrollee:

- Is under the age of 7 with a dental condition that cannot be safely and effectively treated in a dental office;
- Is an individual with a physical or developmental disability whose dental condition cannot be safely and effectively treated in a dental office; or
- Has a medical condition the physician determines would place the enrollee at undue risk if the procedure were performed in a dental office (the procedure must be approved by the enrollee's physician).

General anesthesia means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide is not reimbursable as general anesthesia.

Services of a dentist are covered *only* for the following:

- Excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth, or restorative surgery required by the excision.
- Incision of salivary glands or ducts.
- Obturator maintenance for cleft palate, gum reduction for gingival hyperplasia due to Dilantin/phenytoin, or jaw reconstruction due to cancer.
- Preauthorized surgical treatment for temporomandibular joint (TMJ) conditions.
- Reduction of a fracture or dislocation of the jaw or facial bones.
- Repair of accidental injury to natural teeth, including evaluation of the injury and development of a treatment plan (services must be based on an evaluation and treatment plan completed within 30 days of the injury unless delay is medically indicated and the treatment plan is modified).

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Diabetes Education

This benefit covers a diabetes education program approved by Medicare or otherwise authorized by UMP. The benefit follows Medicare protocol and criteria for:

- Newly diagnosed diabetics.
- Diabetics whose treatment regimen is changed from diet control to oral diabetes medication, or from oral diabetes medication to insulin.
- Diabetics with inadequate glycemic control as evidenced by an HbA1c level of 8.5% or more on two consecutive HbA1c determinations three or more months apart in the year before training begins.
- Persons who are at high risk for complications from inadequate glycemic control including lack of feeling in the foot or other foot complications such as foot ulcers, deformities or amputation, preproliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes.

Diabetes education services must be prescribed by an approved provider type.

Diagnostic Tests, Laboratory, and X-Rays

This benefit covers:

- Diagnostic laboratory tests, x-rays (including diagnostic mammograms), and other imaging studies.
- Electrocardiograms (EKG, ECG).
- Electroencephalograms (EEG) and similar tests.
- Pathology exams.
- Screening and diagnostic procedures during pregnancy and related genetic counseling for prenatal diagnosis of congenital disorders.
- Studies and exams to establish a diagnosis or monitor the progress and outcome of therapy.

These tests must be appropriate to the diagnosis or symptoms reported by the ordering provider.

Colonoscopies for enrollees age 50 or over will be covered under the preventive care benefit regardless of diagnosis.

Positron Emission Tomography (PET) scans require preauthorization.

Genetic testing requires preauthorization; genetic testing unrelated to pregnancy may be authorized only when performed by a specialist center/provider designated by the UMP.

Charges for Magnetic Resonance Imaging (MRI) are covered when determined medically necessary *and* appropriate to diagnose a specific condition.

Screening mammograms in conjunction with a covered routine physical exam (subject to U.S. Preventive Services Task Force guidelines) are covered under the preventive care benefit.

In cases of alternative diagnostic approaches with different fees, the UMP PPO will cover the least expensive, medically reliable diagnostic method.

Electron Beam Tomography (EBT), self-referred or prescribed by your provider, is not covered.

Dialysis

Outpatient professional and facility services necessary for dialysis are covered when prescribed by an approved provider type to treat a covered condition. Independent dialysis facilities are covered at 80% of allowed charges. Dialysis facilities within a hospital or skilled nursing facility setting are reimbursed based on the network, non-network, or out-of network status of the hospital.

Durable Medical Equipment, Supplies, and Prostheses

Preauthorization of durable medical equipment for rentals more than three months or purchases over $1,000 is required.

This benefit covers services and supplies prescribed by an approved provider type to treat a covered condition, including:

- Artificial limbs or eyes (including implant lenses prescribed by a physician and required as a result of cataract surgery or to replace a missing portion of the eye).
- Breast pump for a medical condition of the mother or infant, such as a premature baby with difficulty sucking.
- Casts, splints, crutches, trusses, and braces.
- Contraceptive supplies that require a prescription, such as diaphragms.
- Diabetes care equipment (nondisposable) such as glucometers, insulin injection aids, and insulin pumps as well as accessories.
- Disposable diabetic supplies not purchased in a retail pharmacy or through our mail-service pharmacy.
- Foot care appliances to prevent diabetes complications.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

- Initial external prosthesis and bra required by breast surgery and replacement of these items when necessitated by normal wear, a change in medical condition, or additional surgery (also see "Mastectomy and Related Services" on pages 26-27).
- Ostomy supplies.
- Oxygen and rental equipment for its administration.
- Penile prosthesis when impotence is caused by a covered medical condition (not psychological), is a complication directly resulting from a covered surgery, or is a result of an injury to the genitalia or spinal cord *and* other accepted treatment has been unsuccessful.
- Rental or purchase (at the UMP's option) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees cannot exceed full purchase price).
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100.

Equipment charges in excess of the charge for less costly equipment that serves the same medical purpose are not covered. It may help you to request preauthorization for frequently prescribed durable medical equipment items such as light boxes, hospital beds, and breast pumps. Otherwise, processing of these claims is suspended pending determination of medical necessity.

Note that durable medical equipment is covered at the network benefit rate only if you obtain the equipment or supply from a UMP PPO network durable medical equipment supplier or other network provider.

Disposable supplies to treat diabetes purchased at a retail pharmacy or through our mail-service program are covered under the "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" benefit starting on page 30. Prescription drugs used in conjunction with durable medical equipment are also covered under the "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" benefit.

Emergency Room

This benefit is subject to a separate $75 copay per visit in addition to your enrollee coinsurance and annual medical/surgical deductible. It covers emergency room services for diagnosis and emergency treatment of a covered illness or injury. If the UMP determines emergency care is not medically necessary or could be rendered in a nonemergency setting with equal effectiveness, no benefits will be paid for emergency room services.

The emergency room copayment is waived if there is a direct hospital inpatient admission. However, the hospital inpatient services copayment or enrollee coinsurance will apply in these cases. See the "Summary of Benefits" for coinsurance/copayment details.

Hearing Care

This benefit is limited to $400 per enrollee in any 36 consecutive months. It covers:

- Hearing exams and evaluations related to the purchase of a hearing aid.
- Purchase of a hearing aid (monaural or binaural) prescribed as a result of the exam/evaluation, including:
  - Ear mold(s).
  - Hearing aid instrument.
  - Initial battery, cords, and other ancillary equipment.
  - Warranty and follow-up consultation within 30 days after delivery of hearing aid.
- Rental charges up to 30 days, if you return the hearing aid before actual purchase.
- Repair of hearing aid equipment.

To expedite claim payment for this benefit, submit the bills for the hearing exam and hearing aid purchase at the same time. Treatment for diseases/disorders of the ear or auditory canal (not related to a routine hearing exam) are covered as any other condition and not subject to the hearing care benefit limit.

Home Health Care

UMP preauthorization is required for home health care in which:

- Visits are daily;
- Visits are expected to exceed two hours a day; or
- Length of treatment is expected to last more than three weeks.

Reauthorization is required every two weeks unless otherwise approved by Medical Review. *Please call the UMP at 1-888-759-4855 prior to the start of home health services in these cases.*

This benefit covers services provided and billed by a licensed home health agency to treat a covered illness or

injury. Services must be part of a prescribed written treatment program. The provider must certify that you are homebound and that hospital or skilled nursing facility confinement would be required in the absence of home health care. Covered expenses include:

- Ancillary services such as intermittent care (less frequently than daily visits, and under two hours per visit) from home health aides and clinical social services, provided in conjunction with the skilled services of an RN, LPN, or physical, occupational, or speech therapist.
- Disposable medical supplies as well as prescription drugs.
- Home infusion therapy.
- Visits for part-time or intermittent skilled nursing care and for physical, occupational, and speech therapy.

Hospice Care (Including Respite Care)

If preauthorized, hospice care provided by network providers is covered at 100% of allowed charges. If not preauthorized, the normal UMP PPO benefit will apply.

This benefit covers hospice care for a terminally ill enrollee for up to six months. The UMP may grant an extension if hospice care benefits have been exhausted. Services must be part of a written program of care developed by a state-licensed or Medicare-approved hospice.

The benefit includes:

- Inpatient services and supplies provided by the hospice when ordered by the attending provider such as prescription drugs, medical supplies normally used for inpatients, and rental of durable medical equipment.
- Respite care for a homebound hospice patient (continuous care of more than four hours a day to give family members temporary relief from caring for the patient), which is covered up to a $5,000 lifetime maximum.

Hospital Inpatient Services

This benefit covers hospital accommodation and the following inpatient services, supplies, equipment, and prescribed drugs to treat covered conditions:

- Blood and blood derivatives.
- Bone, skin, and eye bank services.
- Diagnostic tests and exams.
- General nursing care.
- Prescription drugs administered during an inpatient stay.
- Radiation and x-ray therapy.
- Surgery.
- Take-home prescription drugs dispensed and billed by the hospital upon discharge.

Inpatient physical, occupational, speech, and massage therapy requires preauthorization.

When the hospital has only private rooms, the UMP PPO will determine payment based on semiprivate room rates charged by other facilities in the area. Hospitals may bill you for the additional costs of certain high-cost services or devices that do not meet the medical necessity criteria of "the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention." Examples of services for which there may be additional charges include metal-on-metal or ceramic hip prostheses. Note that a *network* facility may not bill you for the difference between the standard service and the enhanced service, unless you agreed in writing to these charges prior to the service being provided.

In some cases, special-care unit accommodations, such as in a cardiac, intensive care, or isolation unit, may be covered based on the facility's special-care room rates.

Hospital Outpatient Services

This benefit covers services for outpatient surgery, day surgery, short-stay obstetrical services (discharged within 24 hours of admission), or observation services of less than 24 hours. It also includes outpatient ancillary services such as lab, x-rays, radiation therapy, IV infusion therapy, and physical, occupational, and speech therapy.

Mastectomy and Related Services

This benefit covers restorative surgery necessitated by previous surgery covered under the UMP as well as mastectomy necessitated by disease, illness, or injury.

An enrollee receiving benefits in connection with a mastectomy who elects breast reconstruction in connection with the mastectomy is covered for:

- Reconstruction of the breast on which the mastectomy was performed.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Physical complications of all stages of mastectomy, including lymphedemas.

Mental Health Treatment

This benefit covers hospital inpatient and outpatient services as well as professional services to treat neuropsychiatric, mental, or personality disorders, including eating disorders (bulimia and anorexia nervosa). Services from mental health providers for a mental health disorder are covered under this mental health treatment benefit, regardless of the cause of the disorder (such as postpartum depression).

Inpatient mental health treatment is limited to 10 days per calendar year. Outpatient mental health treatment is limited to 20 visits per calendar year. Visits for the sole purpose of medication management do not count toward the outpatient visit limit, and are instead covered as medical services.

As an alternative to inpatient care, the UMP PPO covers partial hospitalization services. With preauthorization, partial hospitalization services may count toward inpatient benefit limits at a rate of two partial hospitalization days per inpatient day, until the 10-day limit on inpatient services has been met. Partial hospitalization services (see page 67) will be considered outpatient services for determining applicable enrollee coinsurance. If you reach the 10-day limit for inpatient services, or if you do not obtain preauthorization, partial hospitalization services will count toward the 20-visit limit for outpatient services.

Marital, family, and sexual counseling are not covered. However, services of a licensed marriage and family counselor are covered when provided to treat neuropsychiatric, mental, or personality disorders.

Biofeedback therapy is covered under this benefit when prescribed as part of an overall treatment plan for a mental health condition.

Mental health treatment must be provided or directed by one of the following:

- Licensed community mental health agency.
- Licensed nurse practitioner (ARNP) with training in psychology and counseling.
- Licensed physician.
- Licensed psychologist.
- Licensed Master of Social Work, Licensed Mental Health Counselor, or Licensed Marriage and Family Therapist.
- Licensed state hospital.

Services from non-PhD psychologists are covered under this benefit only when they are employed by and deliver services within a licensed community mental health agency *and* that agency bills for the services.

Mental Health Services and Your Rights

UMP and state law have established standards to:

- *Help ensure the competence and professional conduct of mental health service providers.*
- *Support your right to receive treatment only after informed consent.*
- *Protect the privacy of your medical information.*
- *Help you understand which services are covered under UMP PPO and the limits on your coverage.*

For more infomation about covered mental health services, or if you have a question or concern about your mental health benefits, please contact the UMP.

If you think any mental health benefit you have received from UMP PPO may not conform to the terms of your coverage contract or your rights under the law, contact the UMP at 206-521-2000. If you have a concern about the qualifications or professional conduct of your mental health provider, call the Washington State Department of Health at 1-800-525-0127 or their customer service department in Health Professions Quality Assurance at 360-236-4902.

Naturopathic Physician Services

This benefit covers services of a naturopathic physician. Herbs and other nonprescription drugs, lotions, vitamins, or minerals prescribed as part of naturopathic care are not covered.

Neurodevelopmental Therapy for Children Ages 6 and Younger

Children ages 6 and younger are covered for neurodevelopmental therapy to assist with motor or sensory skill, such as speech therapy for developmental disorders of articulation, language therapy to correct developmental language delay, or diagnosis or treatment of learning disabilities. Benefits are payable only where

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

significant deterioration in the child's condition would result without such services, or to restore and improve the child's functions.

Inpatient therapy is subject to the hospital inpatient copayment or enrollee coinsurance and limited to 60 days per calendar year. Outpatient care is covered up to 60 visits per calendar year for all therapies combined.

This benefit includes only the services of UMP approved provider types authorized to perform the therapy. Licensed massage practitioners must be UMP network providers to be covered. Services must be part of a formal written treatment plan developed in consultation with the clinician diagnosing the condition and prescribing the therapy. The child is not eligible for both the "Physical, Occupational, Speech, and Massage Therapy" benefit and this benefit for the same type of services for the same condition, unless preauthorized by the UMP as a case management benefit exception.

Obstetric and Newborn Care

Preauthorization is required for prenatal diagnostic screening for congenital disorders.

This benefit covers services for pregnancy and its complications when provided and billed by a licensed physician, nurse practitioner, licensed midwife or certified nurse midwife, hospital, or birthing center. Services must be determined necessary and appropriate by both the attending provider and the mother, based on accepted medical practice. Except in geographic areas where provider access is limited, the benefit includes only services provided by providers able to perform the full scope of obstetric services (prenatal, delivery, and postnatal care). Professional services include prenatal and postpartum care, prenatal testing (in accordance with the standards set forth in WAC 246-680-020), vaginal or cesarean delivery, and care of complications resulting from pregnancy. Hospital services are covered for obstetric care subject to the inpatient hospital copayment or enrollee coinsurance. Routine newborn nursery care will be covered during hospitalization of the mother receiving maternity benefits under this plan, and will not be subject to a separate copayment.

Newborn hospitalization for other than routine newborn care is covered subject to the hospital inpatient services copayment and/or enrollee coinsurance for the first 21 days from the date of birth, if the mother is covered by this plan.

Benefits for professional and other newborn follow-up care are also provided subject to any applicable deductible, copayment, or enrollee coinsurance amounts for the first 21 days from birth if the mother is covered by this plan. For newborn services beyond 21 days, the child must meet the plan's dependent eligibility as well as enrollment requirements, and any applicable premium must be paid.

For information on adding a new dependent to your coverage, see page *55 (or call PEBB Benefit Services at 1-800-200-1004).*

Services related to voluntary and involuntary termination of pregnancy are covered.

Office, Clinic, and Hospital Visits

This benefit covers visits involving face-to-face interaction between patient and provider for diagnosis or treatment of covered conditions.

Family planning services (including contraceptive supplies requiring a prescription or fitting, or surgical implantation/insertion of contraceptive devices such as IUDs, cervical caps, and long-acting progestational agents) are covered as well.

This benefit also includes visits by the surgeon, assistant surgeon, and anesthesiologist in performing:

- Cosmetic, plastic, and reconstructive surgery, including related services and supplies, if necessary to improve or restore bodily function lost due to a nonoccupational accident occurring while you're covered, or a congenital anomaly (such as cleft palate or spina bifida) in a covered dependent child.
- Elective sterilization (tubal ligation and vasectomy).
- Limited dental services (see page 23).
- Mastectomy and related covered benefits (see pages 26-27).
- Surgery for a covered condition.
- Restorative surgery necessitated by previous surgery covered under the UMP.

Organ Transplants

Preauthorization is required for organ transplants. This benefit covers services related to organ transplants (bone marrow and stem cell are considered organs for purposes of this benefit), including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care. Donor expenses are covered as defined on the next page.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Related services such as outpatient prescription drugs, and outpatient laboratory and x-rays may be covered under other UMP PPO benefits.

Organ transplants will be covered when they are preauthorized, are performed in a plan-designated facility, and meet all of the following criteria:

- The service is required because of a disease, illness, or injury and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.
- There is sufficient evidence to indicate that the service will directly improve the length or quality of the enrollee's life. Evidence is considered to be sufficient to draw conclusions if it is from published peer-reviewed medical literature (see definition on page 67), is well-controlled, directly or indirectly relates the service to the length or quality of life, and is reproducible both within and outside of research settings.
- The service's expected beneficial effects on the length or quality of life outweigh its expected harmful effects.
- The service is a cost-effective method available to address the disease, illness, or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the enrollee that is more conservative or substantially less costly.

In addition, you must have been accepted into the treating facility's transplant program and continue to follow that program's protocol.

Costs to remove the organ from the donor and to treat complications directly resulting from the surgery are covered by the recipient's UMP PPO coverage if the:

- Donor is not eligible for coverage under any other health care plan or government-funded program;
- Organ recipient is enrolled in UMP PPO; and
- Organ transplant meets the above coverage criteria.

Benefit Limitations: Transplants are covered only if preauthorized and performed in a plan-designated facility (see definition on page 67). Coverage of direct medical costs for bone marrow, stem cell, and umbilical cord donor searches is limited to a combined total of 15 donor searches per transplant. No other benefits are provided for services related to locating an organ transplant donor.

Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)

This benefit covers services for outpatient surgery, day surgery, services at an ambulatory surgical center (ASC), or short-stay obstetric services (discharged within 24 hours of admission). *Depending on the procedure, a separate surgical suite/facility charge is not covered in some circumstances*. Although network providers cannot bill you for noncovered surgical suite/facility charges, you're responsible for these charges if billed by a non-network or out-of-network provider.

A doctor may be a network provider, yet perform services at a non-network day surgery/ASC. Be sure to confirm whether the facility is in the UMP network prior to receiving services.

Phenylketonuria (PKU) Supplements

Phenylketonuria (PKU) supplements are covered when prescribed and used to treat PKU.

Physical, Occupational, Speech, and Massage Therapy

Inpatient physical, occupational, speech, and massage therapy must be preauthorized.

This benefit covers inpatient and outpatient services to improve or restore function lost due to:

- An acute illness or injury;
- An exacerbation of a chronic injury; or
- A congenital anomaly (such as cleft lip or palate) in a covered dependent child.

Inpatient rehabilitation therapy services are covered to a maximum of 60 days per calendar year subject to the hospital inpatient copayment and/or enrollee coinsurance. If the UMP determines inpatient care is not medically necessary or could be received in an outpatient setting with equal effectiveness, no benefits will be paid for inpatient care.

Outpatient therapy services are covered to a maximum of 60 visits per calendar year for all therapies combined.

Services must be part of a formal written treatment plan developed in consultation with the clinician who diagnosed your condition and prescribed the therapy. Licensed massage practitioners must be UMP network providers to be covered. Massage therapy services exceeding one hour must be preauthorized.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

The UMP PPO will not cover the same type of services for the same condition under both this benefit and the "Neurodevelopmental Therapy" benefit unless preauthorized as a case management benefit exception.

Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies

This benefit covers legend drugs (those that can be legally obtained only with a written prescription) approved by the Food and Drug Administration (FDA) including:

- Allergy antigens.
- Chemotherapeutic agents for treatment of malignancies.
- Contraceptive drugs.
- Injections of certain prescription medications.
- Fluoride for prevention of dental caries in preschool children (see page 32).
- Methadone.
- Prenatal vitamins (during pregnancy).

Certain nonprescription drugs and supplies are also covered including:

- All insulin and all disposable diabetic supplies such as test strips, lancets, and insulin syringes used in the treatment of diabetes.
- Prenatal vitamins (during pregnancy).
- Nicotine replacement therapy (NRT) when recommended for participants in the *Free & Clear* tobacco cessation program.
- Over-the-counter products listed on the UMP Preferred Drug List (UMP PDL).

Insulin, prenatal vitamins, NRT, disposable diabetic supplies, and over-the-counter products listed on the UMP PDL are covered only when accompanied by a written prescription from an approved provider type.

To be covered, drugs must be prescribed and/or administered by a provider authorized by law to do so.

UMP PPO prescription drug benefits are payable only for medically necessary medications and supplies. Services must be received from a licensed pharmacy employing licensed registered pharmacists.

Prescriptions from both retail pharmacies and our mail-service pharmacy are subject to the $100 per person annual prescription drug deductible.

The amount you pay varies based on the following three drug "tiers" (categories):

Tier 1: Generic drugs, all insulin, and all disposable diabetic supplies

Tier 2: Preferred brand-name drugs

Tier 3: Nonpreferred brand-name drugs

See "Your Prescription Drug Benefit Amount" and the "Summary of Benefits" for additional information on the tiers and specific cost-sharing requirements.

An FDA-approved drug used for off-label indications (that is, prescribed for a use other than its FDA-approved label) is covered only if recognized as effective for treatment:

- In a standard reference compendium (defined on page 68).
- In most relevant peer-reviewed medical literature (defined on page 67), if not recognized in a standard reference compendium.
- By the federal Secretary of Health and Human Services.

No benefits will be provided for any drug when the FDA has determined its use to be contraindicated.

Certain drugs may require preauthorization. In addition, the UMP PPO may limit medications to specific circumstances and protocols or restrict initial and/or refill quantities where there is:

- A sound clinical basis.
- Inadequate evidence of cost-effectiveness.
- Evidence of lack of cost-effectiveness.

See "Drug Coverage Management" on page 21 for specific details.

You may receive up to a 90-day supply of medications at either a retail pharmacy or our mail-service pharmacy unless otherwise limited by the amount authorized by your prescriber, drug coverage management, preauthorization requirements, plan exclusions or limits, or drug availability. Specialty drugs (those that require special handling or administration) are limited to a 30-day supply at retail pharmacies and a 90-day supply at our mail-service pharmacy.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Although in most cases you can receive up to a 90-day supply of your prescription drug, the actual supply depends on the provider prescribing the medication. If your provider orders less than a 90-day supply, the pharmacist cannot give you more. At mail-service, if your prescription is for less than a 90-day supply, your copayment will not be prorated.

See "Your Prescription Drug Provider Options" on pages 15-16 for more information on your choice of pharmacies.

The UMP has a preferred drug list, which for many drug classes is based on the Washington Preferred Drug List (Washington PDL) used by several state programs. This list was developed using evidence-based criteria for safe, effective, and appropriate prescribing. Your doctor may prescribe a preferred drug or any other drug he or she thinks is medically necessary for you. However, please note that the amount you pay for your prescription will depend on which tier it falls in (see page 17) and where you purchase it.

UMP retains the right to update the UMP Preferred Drug List (UMP PDL) or shift medications to different tiers during the year if generic or over-the-counter alternatives become available, or if there are changes to the Washington PDL or Express Scripts' National Formulary. UMP will notify enrollees about any changes to the UMP PDL or the Drug Coverage Management programs if these occur during the year.

In many drug classes, when your prescribing provider allows substitution on your prescription for a nonpreferred brand-name drug, your pharmacist may be required to substitute the UMP preferred drug. This is a requirement under a new state law that applies only to state-operated prescription drug programs (such as UMP) and prescribers who have endorsed the state's preferred drug list. You may ask your pharmacist to dispense the nonpreferred drug, but your out-of-pocket costs will be higher (Tier 3).

Mail-Service Pharmacy

You may order drugs by mail using our mail-service pharmacy, applying the same annual prescription drug deductible, preauthorization requirements, and limits as for retail prescription drugs.

Prescriptions mailed or orders placed in December but not processed until January 1 or after, will be subject to the annual prescription drug deductible applicable **on the date the prescription is processed**. Due to increased volume at the end of the year, UMP cannot guarantee that prescriptions submitted to our mail-service pharmacy in December will be processed under the current benefit year.

If there is a manufacturer shortage of a specific drug (or other shortage that our mail-service pharmacy cannot control), and the quantity available is less than the quantity you ordered, the copayment will not be prorated. The original copayment applicable for up to a 90-day supply is charged.

Preventive Care

This benefit is not subject to the annual medical/surgical deductible. It covers the services in the tables that follow.

Benefits for well-baby care and routine physical exams for children and adults, including immunizations, were designed based on the U.S. Preventive Services Task Force guidelines, recommendations of the National Immunization Program of the Centers for Disease Control and Prevention, and recently published peer-reviewed literature on preventive care.

Services are provided on an outpatient basis specifically to monitor and maintain health and to prevent illness.

When received from a UMP network provider, the specified preventive care services shown in this section are covered at 100% of allowed charges (no deductible, coinsurance, or copayments).

If you receive preventive services that exceed those listed here, they will not be reimbursed under the UMP PPO's preventive care benefit. Instead, when medically necessary they will be reimbursed under the specific benefit the charges apply to (such as diagnostic tests, or laboratory and x-rays) and will be subject to the annual medical/surgical deductible. If your provider does not bill for a routine physical exam code and instead documents a diagnosis on your claim, the services are not considered preventive.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once in 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to the UMP in writing.

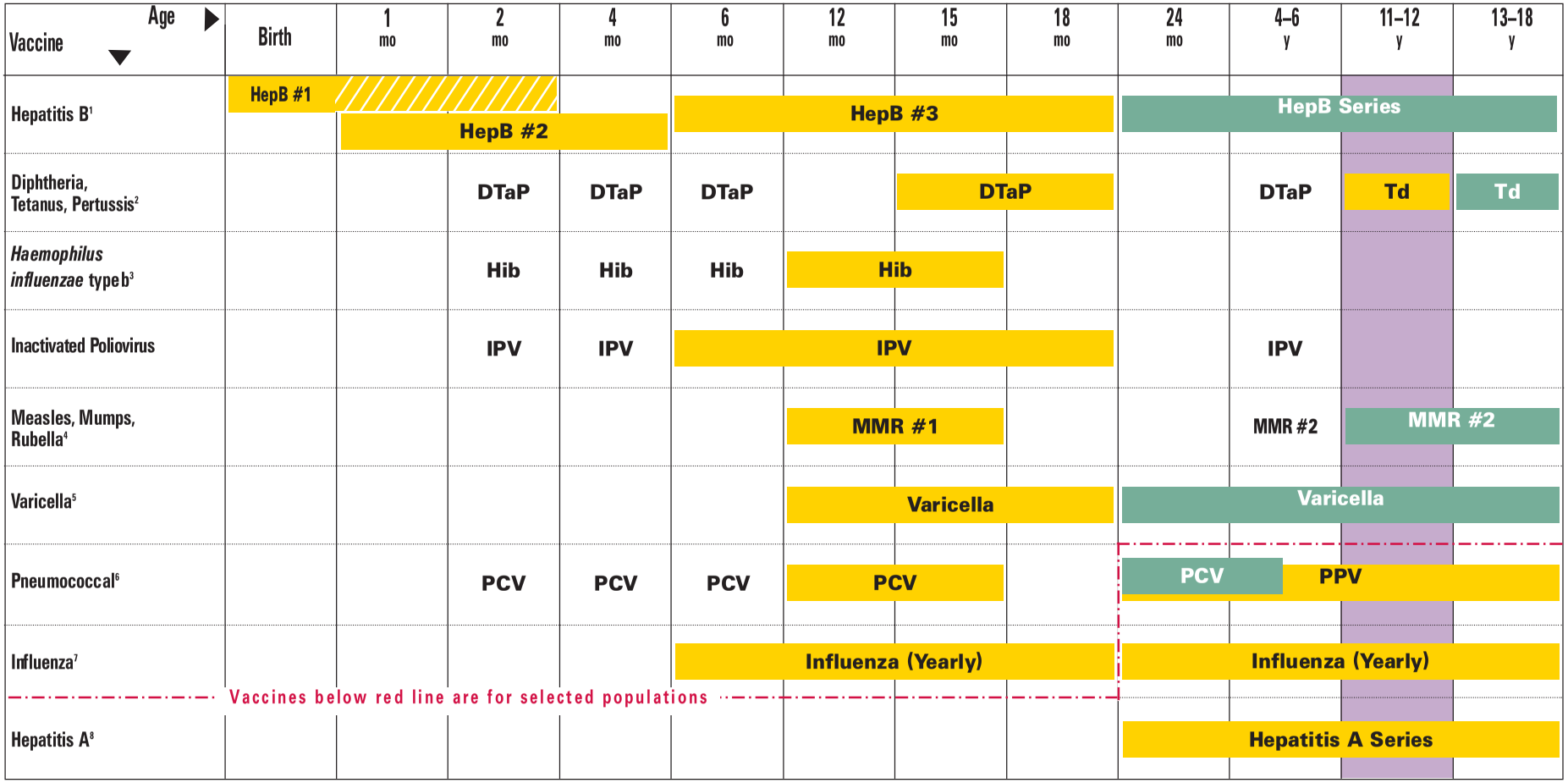
Children: Birth-6 years	
Screening exams	
Age	**Service covered**
2-4 days	Preventive health visit or home health visit, if your baby was discharged early.
Within 30 days	Preventive health visit.
2 months	Preventive health visit.
4 months	Preventive health visit.
6 months	Preventive health visit. Oral fluoride for preschool children older than 6 months if primary water source deficient in fluoride.
9 months	Preventive health visit with hemoglobin/hematocrit and/or lead screening if child at risk.
12 months	Preventive health visit.
15 months	Preventive health visit.
18 months	Preventive health visit.
2-6 years	Annual preventive health visit.

Children: Ages 7-18 years	
Screening exams	
Age	**Service covered**
8 years	Preventive health visit.
10 years	Preventive health visit.
11-18 years	Up to annual preventive health visit.
18 years	Females: Pap smear and chlamydia screening (earlier if sexually active).

The graph and explanation on the following pages represent the immunization schedule for children from birth to age 18 recommended by the National Immunization Program of the Centers for Disease Control and Prevention.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • JULY–DECEMBER 2004



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of April 1, 2004, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible.

Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form can be found on the Internet: *www.vaers.org* or by calling 800-822-7967.

- Range of recommended ages
- Only if mother HBsAg(-)
- Preadolescent assessment
- Catch-up immunization

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC SAFER·HEALTHIER·PEOPLE™

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices *www.cdc.gov/nip/acip*
American Academy of Pediatrics *www.aap.org*
American Academy of Family Physicians *www.aafp.org*

Footnotes

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • JULY–DECEMBER 2004

1. Hepatitis B (HepB) vaccine. All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is hepatitis B surface antigen (HBsAg) negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.

Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL of Hepatitis B Immune Globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9–15 months.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. *Haemophilus influenzae* type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB or ComVax [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters following any Hib vaccine. The final dose in the series should be given at age ≥12 months.

4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the visit at age 11–12 years.

5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons age ≥13 years should receive 2 doses, given at least 4 weeks apart.

6. Pneumococcal vaccine. The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children age 2–23 months. It is also recommended for certain children age 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9):1-35.

7. Influenza vaccine. Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, and diabetes), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2004;53;[RR-6]:1-40) and can be administered to all others wishing to obtain immunity. In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine, because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2004;53;[RR-6]:1-40. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if 6–35 months or 0.5 mL if ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

8. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The 2 doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(RR-12):1-37.

Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once in 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to the UMP in writing.

Men: Ages 19 Years and Older	
Screening exams	
Age	**Service covered**
19-64 years	Preventive health visit every 1-3 years.
19+ years	Fasting blood glucose testing every 1-3 years for patients with established diagnosis of hypertension or established diagnosis of hyperlipidemia.
35-65 years	Blood cholesterol/lipids screening every 5 years.
50+ years	Fecal occult blood test for colorectal cancer at each preventive health visit.
50+ years (or younger if at risk)	Flexible sigmoidoscopy once every 48 months. Colonoscopy once every 10 years, but not within 48 months of screening sigmoidoscopy.
50+ years	PSA (Prostate Specific Antigen) once a year at physician discretion.
65+ years	Preventive health visit once a year.
Immunizations	
Age or other indications	**Service covered**
19+ years	**Tetanus/Diptheria (Td) booster** once every 10 years.
19+ years	**Varicella** (if no history of chickenpox and not previously immunized).
19+ years	**Influenza vaccine**, annually.
College students, living in dormitories	**Meningococcal vaccine**, once.
40 years	**Measles/Mumps/Rubella (MMR)** second dose if not administered previously.
65+ years (or younger with chronic illness)	**Pneumococcal vaccine**—once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Women: Ages 19 and Older	
Screening exams	
Age	**Service covered**
19-64 years	Preventive health visit every 1-3 years.
19+ years	Fasting blood glucose testing every 1-3 years for patients with established diagnosis of hypertension or established diagnosis of hyperlipidemia.
19-39 years	Pap smear and pelvic exam annually or every 1-3 years after three yearly normal results (chlamydia screening through 24 years).
40+ years	Mammogram every 1-2 years depending on risk factors. Pap smears and pelvic exams every 1-3 years.
45-65 years	Blood cholesterol/lipids every 5 years; after age 65, at physician discretion based on risk factors.
50+ years	Fecal occult blood home test for colorectal cancer during each preventive care visit.
50+ years (or younger if at risk)	Flexible sigmoidoscopy once every 48 months. Colonoscopy once every 10 years, but not within 48 months of sigmoidoscopy.
65+ years	Preventive health visit once a year.
65+ years	Bone density screening using a combination of validated risk questionnaires and densitometry techniques every two years; may begin at age 60 if at risk.
Immunizations	
Age or other indications	**Service covered**
19+ years	**Tetanus/Diptheria (Td) booster** once every 10 years.
19+ years	**Varicella** (if no history of chickenpox and not previously immunized).
19+ years	**Influenza vaccine**, annually.
College students, living in dormitories	**Meningococcal vaccine**, once.
Childbearing age, but not during pregnancy	**Measles/Mumps/Rubella (MMR)** second dose (discuss with provider).

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Radiation and Chemotherapy

This benefit covers therapeutic application of radiation and chemotherapy.

Second Opinions

This benefit covers:

- Second opinions *required* under the UMP's medical review/preauthorization or case management program (failure to obtain a second opinion when required may reduce your benefits by up to $200 or cause denial of benefits).
- Second opinions you *choose* to have, without UMP requirements.

Except in an emergency, a second opinion is almost always a good idea before any major procedure or treatment program. The benefit of a second opinion may be greatest if you:

- Tell your attending physician you would like a second opinion.
- Try to get your opinion from a doctor unaffiliated with the first (preferably practicing at another institution).
- Consider seeking a second opinion on surgery from a non-surgeon.
- Let the second opinion provider know that you expect to have a thorough review of records, interview, and physical exam.

Required second opinions are covered at 100% of the allowed charge and are not subject to the annual medical/surgical deductible.

Skilled Nursing Facility

Preauthorization is required for inpatient skilled nursing facility benefits.

This benefit covers accommodations, services, and supplies to treat an accidental injury, illness, or other covered condition–when provided in and billed by a state-licensed, Medicare-certified skilled nursing facility.

You must require continued services of skilled medical or allied health professionals that cannot be provided on an outpatient basis. Benefits are limited to 150 days per calendar year, unless the UMP approves additional coverage in place of inpatient hospitalization.

Skilled nursing facility confinement for individuals with mental health conditions or retardation, or for care that is primarily domiciliary, convalescent, or custodial in nature is not covered.

Special Nursing Services

Acute skilled nursing services provided in the home or hospital by a nurse-level provider, and not received through a hospice or home health care agency, are covered to a maximum of $5,000 per person per calendar year.

Spinal and Extremity Manipulations

Manipulations of the spine or extremities, performed by a chiropractor, osteopathic physician, or other approved provider type, including related office visits and diagnostic tests/x-rays, are covered to a combined total of 10 visits per calendar year. (One or more of these services performed in a single encounter will count as one visit.)

Any diagnostic test, treatment, or x-ray required to diagnose or treat spinal subluxations or covered extremity disorders will be denied once the 10-visit limit has been reached.

Patient education or complementary and preparatory services are not separately reimbursed by the UMP PPO. The UMP defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a spinal and extremity manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service.

Temporomandibular Joint (TMJ) Treatment

Surgical treatment for TMJ disorders is covered when preauthorized. Medical or dental treatment for TMJ disorders is not covered.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Tobacco Cessation Program

This benefit is covered in full and not subject to the annual medical/surgical deductible.

The benefit covers services by the *Free & Clear* tobacco cessation program only, which provides phone counseling and education materials. If nicotine replacement therapy, Zyban, or other drugs are advised by *Free & Clear* counselors, the prescription must be obtained from your provider and will be covered under the prescription drug benefit. These authorized prescription drugs are not subject to the annual prescription drug deductible or enrollee coinsurance/copayment.

For more details or to enroll in the program, call 1-800-292-2336.

Tobacco or smoking cessation programs other than *Free & Clear* are not covered.

Vision Care (Routine)

This benefit is not subject to the annual medical/surgical deductible. It covers routine eye exams, including refractions, once every two calendar years.

An allowance of $100 toward prescription eyeglass lenses, frames, contact lenses, and fitting fees is provided every two calendar years and is not subject to enrollee coinsurance.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Expenses Not Covered, Exclusions, and Limitations

UMP PPO covers only the services and conditions specifically identified in this *Certificate of Coverage.* Unless a service or condition fits into one of the specific benefit definitions, it is not covered. If you have questions, call Customer Service at 1-800-762-6004.

Here are some examples of common services and conditions that are not covered. Many others are also not covered—these are examples only, not a complete list.

1. Acupuncture, except as described under "Acupuncture" in "Covered Expenses."
2. Additional portion of a physical exam beyond what is covered by the preventive care benefit (starting on page 31), such as that required for employment, travel, immigration, licensing, or insurance and related reports.
3. Alcohol/drug information or referral services or enrollment in Alcoholics Anonymous or similar programs such as services provided by schools or emergency service patrol.
4. All procedures involving selection of embryo for implantation.
5. Air ambulance, if ground ambulance would serve the same purpose, or transportation by "cabulance" or other nonemergency service.
6. Autologous blood and its derivatives, including extraction or storage, except when used for a covered peripheral stem cell rescue procedure.
7. Circumcision, unless determined medically necessary for a medical condition.
8. Complications directly arising from services not covered.
9. Conditions caused by or arising from acts of war.
10. Convalescent or custodial care (intended primarily to assist in activities of daily living and not requiring continued services of skilled medical or allied health professionals).
11. Cosmetic services or supplies, including drugs and pharmaceuticals, except for:
    - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
    - Reconstructive surgery of a congenital anomaly in a covered dependent child.
    - Restoring function.
12. Court-ordered care, unless determined by UMP to be medically necessary and otherwise within UMP PPO's coverage criteria.
13. Dental care other than the specific covered dental services listed on page 23. For example, the following are not covered:
    - Any conditions not directly resulting from an accidental injury.
    - Any treatment of caries or gum disease (including, but not limited to, extractions or aveoloplasties), or other dental-specific services, regardless of the cause.
    - Dental implants.
    - General anesthesia and related facility charges, except as specified under "Dental Services" on page 23.
    - Malocclusion resulting from accidental injury.
    - Nitrous oxide.
    - Nonsurgical treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction.
    - Orthodontic treatment.
    - Orthognathic surgery.
    - Treatment not completed within the time period established in the written treatment plan for an accidental injury.
    - Treatment of injuries caused by biting or chewing.
14. Dietary or food supplements, including:
    - Herbal supplements and homeopathic drugs;
    - Infant or adult dietary formulas, except for treatment of congenital metabolic disorders detected by newborn screening such as phenylkentonuria (PKU) when specialized formulas have been established as effective for treatment;
    - Minerals; and
    - Prescription or over-the-counter vitamins (except prenatal vitamins during pregnancy).

15. Drugs or medicines not prescribed by an approved provider type, or not requiring a prescription, except as listed in exclusion 42.

16. Educational programs, such as nutritional counseling for cholesterol control, or lifestyle modification programs, except diabetes education services as described on page 24; the *Free & Clear* tobacco cessation program described on page 38; and medical nutrition therapy for the treatment of diabetes mellitus and chronic renal insufficiency; end-stage renal disease when dialysis is not received; or the medical condition of an enrollee within 36 months after kidney transplant.

17. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.

18. Equipment such as:
    - Air conditioners or air purifying systems.
    - Arch supports.
    - Corrective shoes (except for diabetes).
    - Convenience items/options.
    - Exercise equipment.
    - Sanitary supplies.
    - Special or extra-cost features.

19. Experimental or investigational services, supplies, or drugs.

20. Foot care routine procedures, treatment of corns and calluses, corrective shoes, treatment of fallen arches or symptomatic complaints of the feet, orthotics, or related prescriptions. (Foot care appliances for prevention or treatment of diabetes complications, however, are covered.)

21. Hearing care services or supplies such as:
    - A hearing aid that exceeds specifications prescribed for correction of hearing loss.
    - Charges incurred after plan coverage ends, unless the hearing aid was ordered before that date and is delivered within 45 days after UMP PPO coverage ends.
    - Purchase of batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.

22. Home health care such as:
    - 24-hour or full-time care in the home, unless preauthorized.
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under "Home Health Care" on pages 25-26.
    - Unless preauthorized:
      - Daily visits;
      - Visits exceeding two hours per day; or
      - Visits beyond three weeks.
    - Dietary assistance.
    - Homemaker, chore worker, or housekeeping services.
    - Maintenance or custodial care.
    - Nonclinical social services.
    - Psychiatric care.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services that are not medically necessary.
    - Supportive environmental materials/ improvements (handrails, ramps, etc.).

23. Homeopathic drugs, including prescription products.

24. Hospice care such as:
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under "Hospice Care" on page 26, or provided in excess of the specified limits.
    - Expenses for normal necessities of living such as food, clothing, or household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the enrollee is receiving home health care benefits.
    - Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling.
    - Supportive environmental materials/ improvements (handrails, ramps, etc.).

25. Hospital inpatient charges such as:
    - Admissions solely for diagnostic purposes that could be performed on an outpatient basis.
    - Beds "reserved" while the patient is being treated in a special-care unit or is on leave from the hospital.
    - High-cost services and devices that do not meet the medical necessity criteria of "the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention." Examples include metal-on-metal or ceramic hip prostheses. See additional information under "Hospital Inpatient Services" on page 26.
    - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items).
    - Private room charges, unless medically necessary and approved by the UMP.
26. Immunizations, except as described under "Preventive Care" starting on page 31. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
27. Impotence or sexual dysfunction treatment with medications or pharmaceuticals.
28. Infertility or sterility testing or treatment, including drugs, pharmaceuticals, artificial insemination, and any other type of testing or treatment.
29. In vitro fertilization and all related services and supplies.
30. Learning disabilities treatment after diagnosis, including for dyslexia, except as described under "Neurodevelopmental Therapy" on pages 27-28.
31. Maintenance therapy (see definition of maintenance care on page 65).
32. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations" on page 37.
33. Marital, family, sexual, or other counseling or training services, except services provided by a licensed marriage and family therapist for neuropsychiatric, mental, or personality disorders.
34. Massage therapy, unless services meet the criteria in "Physical, Occupational, Speech, and Massage Therapy" under "Covered Expenses"; see pages 29-30 . Services from massage therapists who are not UMP network providers, and services that exceed one hour unless preauthorized, are not covered.
35. Mental, neuropsychiatric, or personality disorder treatment, except as described under "Mental Health Treatment" on page 27.
36. Missed appointments, billing fees, or completing or copying forms or records, except copying records to perform retrospective utilization review.
37. Non-network and out-of-network provider charges in excess of the plan's allowed charges.
38. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies, or any bariatric surgery (such as gastroplasty, gastric stapling, gastric banding, or intestinal bypass), regardless of co-morbidities, complications of obesity, or any other medical condition.
39. Organ donor coverage for anyone who is not a UMP PPO enrollee, or for locating a donor (such as tissue typing of family members), except as described under "Organ Transplants" on pages 28-29.
40. Organ transplants or related services in nondesignated facilities, or transportation or living expenses related to organ transplants. See "Plan-Designated Facility" on page 67.
41. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)" on page 38.
42. Over-the-counter drugs, except the following products when prescribed by an approved provider type licensed to prescribe drugs:
    - Insulin;
    - Nicotine replacement therapy (while participating in the *Free & Clear* tobacco cessation program);
    - Over-the-counter products on the UMP Preferred Drug List; and
    - Prenatal vitamins during pregnancy.
43. Prescription drugs that have an over-the-counter equivalent product (identical active ingredients and strength) available in a comparable dosage form.

44. Recreation therapy.
45. Replacement of lost or stolen medications.
46. Residential mental health treatment programs or care in a residential treatment facility.
47. Reversal of voluntary sterilization (vasectomy or tubal ligation).
48. Services or supplies to the extent benefits are *available* under any automobile medical, automobile no-fault, workers' compensation, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (Benefits are considered *available* if they are payable under that other policy, or would be payable if you or someone else made a claim for them and complied with that insurer's claim procedures.) However, UMP PPO payments will be advanced upon request if you agree to apply for benefits under the other insurance or contract and to reimburse the UMP PPO when settlement is received.
49. Services delivered by types of providers not listed as approved on pages 18-19, or by providers delivering services of a type or in a manner not within the scope of their licenses.
50. Services of a non-PhD psychologist, except when employed by and delivering services within a community mental health agency and that agency bills for such services.
51. Services or drugs related to tobacco use and smoking cessation, except as described under "Tobacco Cessation" in "Covered Expenses."
52. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member.
    - That are solely for comfort (except as described in "Hospice Care" in "Covered Expenses" on page 26).
    - For which you are not obligated to pay.
53. Services or supplies, which are normally covered by Medicare, provided when Medicare is the primary payer and obtained through a "private contract" agreement with a physician or practitioner who does not provide services through the Medicare program.
54. Services received outside of required case management when you are required to participate in and comply with a case management plan as a condition of continued benefit payment (see page 20 for details and exceptions).
55. Sexual disorder, diagnosis, or treatment.
56. Sexual reassignment surgery, services, counseling, or supplies.
57. Skilled nursing facility services or confinement for:
    - Individuals with mental health conditions or retardation.
    - Primarily domiciliary, convalescent, or custodial care.
58. Surgical treatment to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
59. Weight-loss drugs, services, or supplies.
60. Wilderness training programs for chemical dependency.

If you have questions about whether a certain service or supply is covered, call the UMP at 1-800-762-6004 or 425-670-3000 in the Seattle area.

Filing a Claim

If you need to submit a claim yourself, follow the steps below.

For services from out-of-network or non-network providers, submit a completed *Uniform Medical Plan Claim Form* to the UMP at the address on the claim form. For prescription drugs from non-network pharmacies, submit a completed *Retail Prescription Drug Claim Form* to the address on the claim form. Forms are available from the UMP or on the UMP Web site at **www.ump.hca.wa.gov**. Prescription drug claim forms are also available through Express Scripts Member Services at 1-866-576-3862, or on UMP's Web site at **www.ump.hca.wa.gov**.

When the UMP PPO is your primary payer (as defined on page 67), *network providers and network pharmacies will bill the plan for you.* (So even if you receive a bill from a network provider, since they're responsible for filing, don't submit the claim.)

Assembling Information

For medical services, your itemized bills should include:

- Patient's name and subscriber identification number.
- Description of the illness or injury (usually a code number).
- Date and type of service.
- Provider's name, address, and fee.

The claim cannot be processed without this information. The *CMS 1500 Form* is the most common form used by providers to bill for professional services. Cash register receipts, balance due statements, or payment receipts can't be used to determine claim payments.

If you go to a non-network pharmacy, you must complete and sign a *Retail Prescription Drug Claim Form* for reimbursement. Pharmacy receipts alone are not acceptable for claim reimbursement unless they identify the drug name(s), date of purchase, dosage, and quantity of the drug as well as the pharmacy name and patient's name.

Submitting Your Claim

All claims for services from out-of-network or non-network providers, or non-network pharmacies, require submission of a completed *Uniform Medical Plan Claim Form* or *Retail Prescription Drug Claim Form*. Claims for insulin, disposable diabetic supplies, prenatal vitamins, over-the-counter drugs on the UMP Preferred Drug List, and nicotine replacement therapy (preauthorized by your *Free & Clear* counselor) must be accompanied by a copy of the prescription from an approved provider type.

Incomplete forms will be returned to you, which will delay the processing of your claim. If Medicare or another health plan is the primary payer on the claim, UMP may need to request the Explanation of Benefits statement issued by the other payer before we can finalize payment on the claim. Submit a separate claim for each person, although multiple medical services or retail prescriptions for the same person may be included on a single form. Do not use nicknames or initials on claim forms or bills. Keep a copy of all documents for your records, and send your medical/surgical claim (or any correspondence about your claim) to:

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

The *Retail Prescription Drug Claim Form* should be sent to:

Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439

The plan will not pay claims submitted more than 12 months after the date of service.

See "Services Received Outside the U.S." on page 19 for additional instructions.

Explanation of Benefits (EOB)

An EOB is the detailed account of each claim processed by a medical plan, which is sent to you to describe claim payment or denial.

EOBs for medical/surgical services display each UMP PPO claim submitted.

EOBs for retail prescription drugs purchased at a participating pharmacy will not be sent unless requested. If an EOB is necessary to coordinate benefits for retail drugs with other coverage, please call Express Scripts Customer Service at 1-866-576-3862, or visit UMP's Web site at **www.ump.hca.wa.gov** to access your private online pharmacy account.

For information on coordinating benefits with another health plan, see "If You Have Other Medical Coverage" on page 50.

What Happens Next

Benefits are calculated according to UMP PPO provisions. As described on the previous page, you will receive an EOB showing how each of your medical/surgical claims was processed. Be sure to keep the original EOB. You may need it for tax purposes or if there are any questions about payment to the provider.

Who Gets the Money When Claims Are Paid

If you use a network provider, the UMP PPO will send payments directly to the provider when the claim is processed. Therefore, you shouldn't pay a network provider for medical/surgical services until the UMP PPO has paid its part of the bill (unless you haven't met your annual medical/surgical deductible).

If you use an out-of-network or non-network provider (other than a hospital), payment may be sent to you or to the provider, depending on your answer to "Have you paid for these charges?" on the claim form, the amount of reimbursement, and whether you assign payment to the provider. Claim payments for hospitals are almost always sent directly to the hospital, regardless of its status as a network, out-of-network, or non-network provider.

When payment goes to the provider, you and the provider receive an EOB detailing what services were covered and how benefits were calculated. Your EOB will have a check attached if payment is due to you.

If you submit claims for retail prescription drug purchases from non-network pharmacies, you will receive reimbursement by mail directly from Express Scripts following the processing of your claim.

If you have questions about filing a claim or the status of a claim, contact UMP Customer Service at 1-800-762-6004 or 425-670-3000 in the Seattle area.

Calculating Benefits When UMP PPO Is Your Primary Coverage: Some Sample Claims

The following examples illustrate how benefits are calculated when UMP PPO is the primary payer. Assume any annual deductible has been met, and any applicable out-of-pocket limit has not been reached.

Network provider in WA, OR, and four Idaho counties (Bonner, Kootenai, Latah, and Nez Perce):

Billed Charge	UMP Allowed Charge	UMP PPO Pays	You Owe
$1,000	$900	$810 (90% x $900)	$90 ($900-$810)

Network provider* (Beech Street) outside WA, OR, and four Idaho counties (Bonner, Kootenai, Latah, and Nez Perce):

Billed Charge	UMP Allowed Charge	UMP PPO Pays	You Owe
$1,000	$900	$720 (80% X $900)	$180 ($900-$720)

Non-network provider:

Billed Charge	UMP Allowed Charge	UMP PPO Pays	You Owe
$1,000	$900	$540 (60% x $900)	$460 ($1,000-$540)

Out-of-network provider (no access to network providers, including outside the U.S.):

Billed Charge	UMP Allowed Charge	UMP PPO Pays	You Owe
$1,000	$900	$720 (80% x $900)	$280 ($1,000-$720)

*Not applicable when Medicare is the primary coverage.

Complaint and Appeal Procedures

Complaints

What Is a Complaint?

A complaint is an oral or written expression of dissatisfaction submitted by or for an enrollee regarding:

- Denial of coverage or payment for health care services or prescription drugs;
- Issues other than denial of coverage or payment, including dissatisfaction, delays, or conflicts with UMP or providers; or
- Dissatisfaction with UMP practices or actions unrelated to health care services or prescription drugs.

Complaints on Medical or Surgical Matters

If you want to make a complaint other than one relating to prescription drugs, call 1-800-762-6004 or 425-670-3000 in the Seattle area from 8 a.m. to 6 p.m. Monday through Friday, or write UMP at:

Uniform Medical Plan
Correspondence
P.O. Box 34578
Seattle, WA 98124-1578

Complaints to UMP regarding medical or benefit issues, providers, and availability of health care will be referred to the UMP Medical Review Department for consideration. If you have a complaint or concern about a health care provider (such as a complaint related to a provider's conduct or ability to practice medicine safely), please contact the Department of Health via e-mail at **hpqa.csc@doh.wa.gov** or 360-236-4700, or visit its Web site (**https://fortress.wa.gov/doh/hpqa1/disciplinary/complaint.htm**) for more information.

Complaints related to nonmedical problems will be referred to the customer service or claims manager depending on the specific concern. Most complaints can be resolved at this level.

If you submit a written complaint, UMP will send confirmation of receipt within five business days. You will also receive notice of the action on your complaint as soon as possible, or within 30 calendar days of receiving your complaint. The UMP will notify you if additional time is needed for a response.

Complaints Relating to Prescription Drugs

If you are dissatisfied with issues related to your prescription drug benefit such as delays, customer service, or pharmacies, call Express Scripts at 1-866-576-3862 or communicate through UMP's Web site at **www.ump.hca.wa.gov**. Most complaints can be resolved at this level. But if your complaint cannot be resolved at this level, you may initiate an appeal within 180 days from the date the action occurred. See "First-Level Appeals" on the next page.

Prescription Drug Coverage Management

For certain drugs, the UMP PPO limits quantity or therapeutic uses for which a drug can be covered over a specific period. Your provider may request coverage for these medications in excess of UMP limits if medically necessary. If you are adversely affected by a limit on a prescription drug that is subject to coverage review (see page 21), then your pharmacist or prescribing provider may call Express Scripts at 1-800-417-8164 to initiate drug coverage review for that particular medication. In some cases, your provider must contact Express Scripts before a decision can be made. You may be eligible for a temporary supply while the coverage review is in process. However, if you choose to receive the drug outside UMP's conditions, you will be responsible for the full cost of any medications for which coverage is denied.

Appeals

What Is an Appeal?

An appeal is an oral or written request submitted by an enrollee or his or her authorized representative for UMP to reconsider:

- UMP's adverse decision regarding a complaint;
- A claim processing issue; or
- UMP's decision to deny, modify, reduce, or terminate payment, coverage, or authorization for health care services or prescription drugs.

You can also appeal decisions related to eligibility. Those include decisions where an adverse benefit decision is based on your not being eligible for coverage or not having paid premiums. Those appeals are handled separately. If your appeal involves those issues, call the Health Care Authority at 1-800-200-1004 or write to:

HCA Appeals Manager
P.O. Box 42699
Olympia, WA 98504-2699

General Information About Appeals

If you are appealing a decision to change, reduce, or terminate coverage for services already being provided, the UMP is required to continue coverage for these services during your appeal. However, if the decision to change, reduce, or terminate coverage is upheld, you will be responsible for any payments made by the UMP PPO during that period. If you are appealing to request payment for denied claims or approval of services not yet initiated, the UMP PPO is not required to cover these services while the appeal is under consideration.

UMP will consult with a health care professional on appeals where the adverse benefit determination was based in whole or in part on a medical judgment. That includes decisions based on determinations that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. The professional consulted in such a case will be one who has appropriate training and experience in the field of medicine involved. The professional will not be someone we consulted in making the earlier decision, or a subordinate of such a person.

Appeals may be filed by mail, fax, phone, or e-mail (send to **umpappeals@hca.wa.gov**).

You may send written comments, documents, and any other information to UMP when you appeal. You may also request copies of documentation UMP has that is relevant to your appeal, which will be provided at no cost. Our review will consider the information you submit to us, including material that was not considered in the initial benefit decision or earlier appeal. Our review will not assume the earlier decision was correct, and will be made by people who did not make the earlier decision and are not subordinates of anyone who did make the earlier decision.

Time Limits for UMP to Decide Appeals

The time limits below apply to both first- and second-level appeals, and are calculated from when UMP receives the appeal.

- The appeal decision will be made within 30 calendar days unless a shorter time limit applies as explained below. UMP will request written permission from you or your representative in cases where we recommend an extension to the 30-day timeline, in order to obtain medical records or a second opinion.
- In appeals involving a denial of a preauthorization request, the appeal decision will be made within 15 days.
- In a situation where delay could seriously jeopardize your life, health, or ability to regain maximum function, or where a physician who knows your condition tells UMP that delay would cause severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal, the appeal decision will be made as soon as possible but always within 72 hours (see "Expedited Appeals" below).
- If the adverse benefit decision was based on the conclusion that the service, drug, or device is experimental or investigational, the appeal decision will be made within 20 calendar days. If the appeal would otherwise have to be decided sooner than in 20 days, the shorter time limit applies.

Expedited Appeals

If your coverage is denied and your provider determines a delay in coverage would seriously jeopardize your life, health, or ability to regain maximum function, ask your provider to request an expedited appeal. All clinically relevant information should be submitted. The provider should contact the UMP by phone, fax, or e-mail at:

Phone: 206-521-2000
Fax: 206-521-2001
E-mail: umpappeals@hca.wa.gov

First-Level Appeals

First-level appeals may be initiated orally or in writing no more than 180 calendar days after you receive notice of the action leading to the appeal. Although appeals may be made by phone or in person, putting them in writing with all of the necessary information will expedite the process.

First-Level Appeals for Medical or Surgical Matters

For medical or surgical appeals, UMP will send confirmation of receipt within five business days. Claim processing disputes will be reviewed by an experienced claims examiner who did not process the original claim. Appeals about covering, authorizing, or providing health care will be evaluated by a medical review nurse not involved in the initial determination to deny, reduce, modify, or terminate services or benefits. If the medical

review nurse's recommendation is to uphold denial of coverage, or a decision is made not to authorize services because they have been determined to be experimental or investigational, or not medically necessary, the appeal will be further reviewed and decided by the UMP medical director or associate medical director.

For appeals involving medical or surgical matters, send first-level appeals to:

Uniform Medical Plan
Medical Review
First-Level Appeal
P.O. Box 34578
Seattle, WA 98124-1578

Fax: 206-521-2001

First-Level Appeals for Prescription Drug Matters

You have the right to appeal if you or your provider disagrees with how your prescription drug claim was processed. That includes claims denial, reduction, or payment issues; applications of drug coverage management guidelines; medical necessity decisions; or drugs denied because of UMP PPO benefit exclusions. To appeal a coverage denial from Express Scripts, you (or your provider on your behalf) can appeal orally or in writing within 180 calendar days of the date you received your notification of denial. In cases involving denial of coverage based on coverage review guidelines or medical necessity decisions, your provider should supply clinically pertinent information to Express Scripts. Therefore, it will expedite the process if your provider initiates these appeals for you.

For appeals involving prescription drug matters, send first-level appeals to:

Express Scripts, Inc.
Attn: Pharmacy Appeals: WA5
6625 West 78th Street
Mail Route BLO390
Bloomington, MN 55439

Fax: 1-877-852-4070
Non-Provider Phone Number: 1-866-576-3862
Provider Phone Number: 1-800-417-8164

Second-Level Appeals

Second-level appeals must be submitted within 180 calendar days of the UMP's decision regarding the first-level appeal. Any additional information you have to support your appeal should be submitted with your request to appeal a determination. For second-level appeals, UMP will send confirmation of receipt within five business days.

Second-level **medical or surgical** appeals should be sent to:

Uniform Medical Plan
Second-Level Appeal
P.O. Box 34578
Seattle, WA 98124-1578

Fax: 206-521-2001

Second-level **prescription drug** appeals should be sent to:

Uniform Medical Plan
Prescription Drug Appeal
P.O. Box 91118
Seattle, WA 98111-9218

Fax: 206-521-2001

The second-level review will be performed by the UMP Appeals Committee, consisting of the UMP executive director or designee, UMP medical director or associate medical director, and Director, Compliance and Enforcement or designee.

Independent Review

You may request an external or "independent" review in two situations. You may request such a review of UMP's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service if UMP exceeds the timelines for response to your appeal without good cause and without reaching a decision. Also, you may request independent review even if UMP has met all timelines but you are dissatisfied with the determination of your second-level appeal. To have an external review, you must ask UMP to send you the forms that must be completed and returned to UMP. These forms authorize UMP to release your medical information to the independent review organization. This process is explained in letter you receive in response to your second-level appeal, or you may call the Appeals Department at 206-521-2000.

To request the forms for an independent review by mail, fax, phone, or e-mail:

Uniform Medical Plan
Independent Review Process
P.O. Box 91118
Seattle, WA 98111-9218

Fax: 206-521-2001
Phone: 206-521-2000
E-mail: umpappeals@hca.wa.gov

The "external review" will be done by an Independent Review Organization, or IRO. An IRO is a group of medical and benefit experts certified by the Washington State Department of Health and not affiliated with the UMP in any way. An IRO is intended to provide unbiased, independent, clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. UMP will pay the IRO's charges.

Any litigation against the UMP must be brought in the Superior Court of Thurston County.

If You Have Other Medical Coverage

The UMP PPO coordinates benefits with any other group health plan covering you so that your UMP PPO and other coverage combined will pay up to 100% of allowed charges (but not more than 100%). **Note:** This may result in your receiving one or more checks for "coordination of benefits (COB) adjustments" during the year. You receive this benefit adjustment because UMP PPO benefits were available but not needed to pay on a claim your primary plan paid. Those saved UMP PPO benefit dollars are later applied to the initial deductible or other, earlier enrollee cost-share expenses that you paid on other claims during that calendar year.

UMP PPO coordinates benefits with the following types of plans:

1. Group or blanket disability insurance policies, and health care service contractor and health maintenance organization group agreements, issued by insurers, health care service contractors, and health maintenance organizations.
2. Labor management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans.
3. Governmental programs (including, but not limited to, Medicare, Medicaid, and workers' compensation) and coverage required or provided by any statute.

Benefits are not coordinated with any individual health coverage you have purchased, only with group plans. Also, this coordination of benefits provision does not apply to prescriptions filled through our mail-service pharmacy.

If you are covered by more than one health insurance plan, please submit claims to UMP PPO and the other plan(s) at the same time. This helps to coordinate benefits more quickly.

The group insurance plan that is *primary* will process the claim first for all covered expenses. The primary plan will pay its normal plan benefit. The other plan(s) that cover you will be considered *secondary* and may pay less than their normal benefit, since total payments combined cannot exceed 100% of the allowed charges. When Medicare or another government program is one of the payers, federal law determines which plan provides benefits first. If you enroll in Medicare and are still an active employee, your Medicare coverage is secondary to UMP PPO; Medicare becomes primary when you retire.

For coordination with plans other than Medicare, the following rules determine which plan is the primary payer:

- When both plans coordinate benefits, the plan covering the person as a subscriber pays first.
- Dependent children are covered first under the plan of the parent whose birthday is earlier in the calendar year. If the parents are separated or divorced, the following rules determine which plan pays first, in this order:
  - Plan of the parent with custody;
  - Plan of the spouse of the parent with custody;
  - Plan of the parent without custody;
  - Plan of the spouse of the parent without custody.

However, if a court decree establishes responsibility for the child's health care, the plan of the parent with that responsibility pays first.

If the rules above do not determine which plan is primary:

- The plan that has covered the *enrollee* for the longer period pays first.
- All other plans provide benefits first if the person is a retiree, a laid-off employee, or a dependent of a person who is retired or laid off if the other plans follow this rule.

When none of the rules above determines which plan is primary, the plan that has covered the *subscriber* for the longer period pays first.

If UMP PPO is the primary payer, the UMP PPO payment will be your normal UMP PPO benefit.

When UMP PPO Is the Secondary Payer

When UMP PPO is secondary to another group health plan or Medicare, standard coordination of benefits applies. However, for our mail-service pharmacy prescriptions, there is no coordination of benefits. This means that UMP PPO is primary and pays first for all covered prescriptions purchased through our mail-service pharmacy, even if you have other coverage that is normally primary.

For other services, here's how it works when UMP PPO is not the primary payer:

- The primary payer pays a portion of the bill and sends you an Explanation of Benefits (EOB); you send a copy of the bill and the EOB to UMP PPO;
- UMP PPO reviews the primary plan benefit calculation, and the primary plan payment;
- UMP PPO determines what the normal benefit would have been if UMP PPO had been the only payer;
- UMP PPO compares allowed charges and determines which is the highest allowed charge; and
- UMP PPO pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP PPO benefit amount.

Here's an example to illustrate the process and terms above. This example assumes that the primary plan ordinarily pays 80% of allowed charges after a $500 deductible.

Provider's charge	**$1,200**	
Primary Plan Benefit Calculation		
Primary plan's allowed charge:	$1,000	
Primary plan deductible:	$500	
Primary plan pays:	$400	(80% of $500 balance)
UMP PPO Benefit Calculation		
UMP allowed charge:	$900	
UMP PPO deductible:	$200	
UMP PPO normal benefit:	$630	(90% of $700 balance)
Actual Payment by UMP PPO		
Highest allowed charge:	$1,000	(primary plan)
Primary plan's payment:	$400	
UMP PPO pays:	***$600***	

In the example above, you owe nothing unless this is a provider who has not agreed to accept the highest allowed charge as payment in full. If a provider is not contracted with UMP PPO or the primary plan as a network provider, you could be billed for the difference between the provider's actual billed charge and the highest of the plans' allowed charges.

Please contact UMP Customer Service at 1-800-762-6004 or 425-670-3000 in the Seattle area for assistance in answering any questions about benefits when you are covered by more than one plan.

Coordination of Benefits (COB) Questionnaire

You will receive a COB questionnaire from UMP every year. This provides UMP with information regarding other health care coverage. Failure to complete the form and return it to UMP may result in delay of claims payment. Please complete and return the form quickly.

When Another Party Is Responsible for Injury or Illness

UMP PPO benefits are available if you're injured or become ill because of another party's action or omission, or if you have a work-related injury not covered by workers' compensation. The UMP PPO will be *subrogated* to your rights against any other party (including workers' compensation and uninsured or underinsured motorist carriers, whether insured or self-funded) liable for payment for the illness or injury, which means UMP PPO:

- Is entitled to reimbursement from any amount you recover from the other party, if you are fully compensated.
- Has the right to pursue claims for damages from the other party.

UMP PPO's subrogation rights extend to the full amount of all benefits the plan paid for the illness or injury. As a condition of receiving benefits for the illness or injury, you and your representatives will cooperate fully with the UMP PPO in recovering paid amounts, including but not limited to:

- Providing facts to the UMP PPO about the illness or injury as well as the identity and address of the other party, and his or her liability insurers and attorneys.
- Giving reasonable advance notice to the UMP PPO of any related trial, hearing, or intended settlement.
- Repaying UMP PPO from the proceeds of any recovery.

More details on these responsibilities follow. (HCA/UMP rights in this section are in addition to any other remedies available under this *Certificate of Coverage* or otherwise provided by law.)

Your Obligation to Notify UMP PPO

You must notify the UMP PPO in writing of any claim or lawsuit for an illness or injury for which the plan paid benefits, including:

- The facts of your illness or injury.
- Any changes in your illness or injury.
- The name of any person responsible for the illness or injury and their insurer.
- Advance notice of any settlement you intend to make.

Right of Recovery

If you bring a claim or lawsuit against another person, you also must seek recovery of any benefits paid under UMP PPO; the plan reserves the right to join as a party. The UMP may, however, recover benefits directly from you or the other person. If so, you don't need to take any action on behalf of the UMP PPO, but you must do nothing to impede the plan's right of recovery.

Right to Receive and Release Information

You may be required to give the UMP or the HCA information necessary to determine eligibility, administer benefits, or process claims. This could include medical and other records. Coverage could be denied if you don't provide the information when requested.

False Claims or Statements

Neither you nor your provider (or any person acting for you or your provider) may submit a claim for services or supplies that were not in fact received, were resold to another party, or for which you are not expected to pay.

In addition, neither you nor any person acting for you may make any false or incomplete statements on any enrollment application under UMP PPO.

The HCA may recover any payments made as a result of a false claim, false statement, or overpayment by UMP PPO by withholding future claim payments or by other means.

Eligibility and Enrollment

Eligibility

(See "When Coverage Begins" to determine when coverage for eligible enrollees begins)

Eligible Employees

Employees (referred to in this book as "employees," "subscribers" or, in some cases, "enrollees") of state government, higher education, K-12 school districts, educational service districts, and employer groups are eligible to apply for coverage by PEBB plans in accordance with PEBB eligibility rules in Chapter 182-12 WAC. An employee is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person.

Eligibility for employees of participating employer groups may follow PEBB rules or rules determined by collective bargaining agreement, if approved by the HCA in accordance with Chapter 182-12 WAC.

Eligible Dependents

Eligible subscribers may enroll dependents in their PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans. For example, a dependent child who is eligible for coverage under two or more parents or stepparents who are employed by PEBB-participating employers, may be enrolled as a dependent under the coverage of one parent or stepparent, but not more than one. The following dependents are eligible:

1. The subscriber's lawful spouse or same-sex domestic partner (qualified through the declaration certificate issued by PEBB).
2. Dependent children through age 19. The term "children" includes the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the subscriber's qualified same-sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as dependents of the subscriber under the Internal Revenue Code, and additional legal dependents approved by the HCA are included. Dependent children beyond the age of 19 are eligible under the following conditions:

   a. Students age 20 through age 23 are eligible if they are registered at an accredited secondary school, college, university, vocational school, or school of nursing. To certify and recertify eligibility, the subscriber must submit a *Student Certification/Change* form to the HCA for review, along with proof that the dependent is a registered student. Acceptable proof may include: i) current quarter/semester registration from the institution; or ii) past year report card/transcript from the institution. When a student no longer meets eligibility criteria, the student's coverage will terminate on the last day of the month in which the loss of eligibility occurred. Misrepresentation or failure to notify PEBB of changes in status resulting in loss of eligibility, including changes in student status, may result in termination of coverage and the subscriber being responsible for payment of services received. Dependent student coverage continues year-round for those who attend three of the four school quarters or two semesters, and for three full calendar months following graduation as long as the subscriber is covered at the same time, the dependent has not reached age 24, and the dependent meets all other eligibility requirements.

Don't forget! Notify PEBB at 1-800-200-1004 as soon as possible of changes in student status. Such changes may result in loss of eligibility.

   b. Dependent children of any age are eligible if they are incapable of self-support and are individuals with disabilities, developmental disabilities, mental illness, or mental retardation, provided that their condition occurred before age 20, or during the time they were covered under a PEBB plan as a registered student. For coverage to continue beyond the limiting age or loss of student eligibility, an application and proof of disability must be submitted to the HCA for approval by UMP. The HCA will, on behalf of UMP, request recertification of disability as

frequently as necessary to verify the ongoing eligibility status of the dependent during the first two-year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.

3. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous coverage in a PEBB-sponsored medical plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible subscriber, (c) the subscriber who claimed the parent as a dependent continues enrollment in a PEBB program, and (d) the parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible subscriber; however, dependent parents may not add additional family members to their coverage.
4. Dependents of an active employee who were previously covered under a K-12 or employer group medical plan, and who are not otherwise eligible for PEBB coverage, may continue coverage under a PEBB plan for up to 36 consecutive months. To be eligible for this continuation, the PEBB plan must be immediately replacing a K-12 or employer group medical plan with no lapse in coverage.

Verification of the dependency status of anyone enrolled under PEBB coverage may be requested at any time by the HCA or UMP.

Medicare Entitlement

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Office to inquire about the advantages of immediate or deferred Medicare enrollment.

For employees and their spouses or qualified same-sex domestic partners age 65 and older, the PEBB-sponsored medical plan will provide primary coverage, and Medicare coverage will be secondary. However, active employees 65 and older may choose to reject PEBB-sponsored medical coverage and choose Medicare as their primary insurer. If an employee does so, the employee will not be allowed to re-enroll in a PEBB medical plan offered to active employees. However, the employee will remain enrolled in PEBB-sponsored dental, life, and long-term disability coverage.

In most situations, employees and their spouses or qualified same-sex domestic partners can elect to defer Medicare Part B enrollment without penalty, up to the date the employee terminates or retires. Upon retirement, Medicare will become the primary insurer and the PEBB-sponsored medical plan becomes secondary.

Please contact the HCA for information about retiree eligibility and benefit information.

Enrollment

(See "When Coverage Begins" to determine when coverage for eligible enrollees begins)

Employees and their eligible dependents may enroll in this plan within 31 days of the date the employee first becomes eligible to apply for PEBB coverage as described in the "Eligibility" section. Enrollment forms are furnished by the employee's payroll, personnel, or insurance office and should be returned to that office within 31 days of the date of eligibility.

Notify your payroll office of address, name, or other changes as soon as possible. This helps ensure that you receive important information about your UMP PPO benefits and helps us serve you better.

Eligible dependents who are not enrolled when they are initially eligible may be enrolled in the subscriber's PEBB medical plan if they lose coverage under another medical plan. Dependents losing other medical coverage must be enrolled within 60 days after termination of the other coverage, and provide proof of continuous coverage to the HCA to establish enrollment eligibility.

Eligible employees and dependents may enroll in PEBB coverage during any PEBB open enrollment period or if the employee acquires a new dependent as a result of marriage, qualified same-sex domestic partnership, birth, adoption or placement for adoption. Eligible employees and dependents may enroll in these situations without proof of continuous coverage.

An employee/dependent is eligible to enroll in only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans.

Waiver of Coverage

Employees eligible for PEBB medical coverage have the option of waiving health plan coverage if they are covered by other health plan coverage. To waive coverage, the employee must complete an *Employee Enrollment/Change* form that identifies the individuals for whom coverage is being waived. If an employee waives coverage for him/herself, coverage is automatically waived for all eligible dependents. An employee may

choose to enroll only him/herself, and waive coverage for any or all dependents.

An employee may only waive the medical portion of health plan coverage. The employee must remain enrolled in the dental, life, and long-term disability insurance coverages.

If PEBB medical coverage is waived, an otherwise eligible person may enroll in a PEBB plan only during the next open enrollment period, or within 60 days of loss of other medical coverage. Proof of other medical coverage is required to demonstrate that: 1) coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 60 days or less.

The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, same-sex domestic partnership, birth, adoption, or placement for adoption, provided that enrollment is requested within 60 days after the date of marriage, establishment of a qualified same-sex domestic partnership, birth, adoption, or placement for adoption.

Enrolling a Dependent Acquired After the Subscriber's Effective Date of Coverage

Subscribers may enroll dependents who become eligible after the subscriber's effective date. Newly eligible dependents must be enrolled within 60 days after the date they become eligible.

1. Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the subscriber should notify his or her personnel, payroll, or insurance office of the birth, or the placement of the adoptive child, as soon as possible to ensure timely payment of claims.

   When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

2. Dependents who lose other medical coverage must enroll within 60 days after the date their other coverage ends. Dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.

3. Eligible dependents may be added during any PEBB open enrollment period without proof of continuous coverage.

Subscribers should contact their personnel, payroll, or insurance office, or the HCA for an *Employee Enrollment/Change* form.

Disenrolling a Dependent

Employees should contact their payroll, personnel, or insurance office for forms and information on how to update their records. A dependent may be deleted from coverage by submitting an *Employee Enrollment/Change* form to the employee's personnel, payroll, or insurance office.

Please refer to the "Options for Continuing PEBB Benefits" section for more information.

Enrollment changes should be made as soon as possible. Eligibility changes not reported within 60 days after an event that creates a change in premium or loss of eligibility may result in a loss of premiums and a loss of the enrollee's right to continued coverage.

Failure to notify your payroll office or PEBB of changes in status affecting eligibility may result in termination of coverage. You are responsible for the cost of any services received when you or your dependent(s) were ineligible.

When Coverage Begins

Coverage will begin for employees and their dependents as follows:

For Employees

1. **Permanent Employees, Seasonal Employees, Career Seasonal/Instructional Employees:** Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment.

2. **Nonpermanent Employees:** Coverage for nonpermanent employees begins on the first day of the seventh calendar month following the date of employment.

3. **Part-Time Faculty:** Coverage for part-time faculty begins on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the

first day of the second consecutive quarter/ semester is the first working day of the month, coverage begins at the beginning of the second consecutive quarter/semester.

4. **Appointed And Elected Officials, Judges:** Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of a month, coverage begins on the first day of their term.

   Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of state government, and judges, on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins, or the oath of office is taken.

5. **Employees of Participating School Districts and Employer Groups:** The effective date of coverage for eligible employees may be determined by the terms of employment or collective bargaining agreement. Participation of the bargaining unit or non-represented employees is subject to approval by the HCA.

For Dependents

Coverage for eligible dependents begins on the day the subscriber's coverage begins if the subscriber lists the dependents on the application for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins on the first day of the month following the date of acquisition or declaration. If the date of acquisition or declaration is the first day of a month, coverage will begin on the first day of the month of acquisition or declaration.

Coverage for a newborn child begins at birth. Coverage for an adoptive child begins on the date that the subscriber assumes a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the first of the month following the date the condition of dependency is established and approved by the HCA. If the condition of dependency is established and approved as of the first day of a month, coverage will begin on the date dependency is established.

Special Enrollment for Employees and Their Dependents Who Previously Waived Coverage

Coverage for eligible employees and their dependents whose medical coverage was previously waived will be effective as described below. The employee must enroll to enroll dependents.

1. Coverage for eligible employees and dependents enrolling because of loss of other medical coverage will begin on the first day of the month following the date the prior coverage terminated. The application must be received by the employee's payroll, personnel, or insurance office within 60 days after termination of other medical coverage, and proof of other continuous comprehensive group medical coverage must be provided.

2. Coverage for eligible employees and dependents enrolling following a marriage or establishment of a qualified same-sex domestic partnership, will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by the employee's payroll, personnel, or insurance office within 60 days after the date of marriage or date that the same-sex domestic partnership qualifies based on the declaration.

3. Coverage for eligible employees and dependents enrolling following a birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the employee assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by the employee's payroll, personnel, or insurance office within 60 days of the birth or date of placement.

Changing Medical Plans Mid-Year

Enrollees may change medical plans in the following situations:

1. During a PEBB open enrollment period.

2. If an enrollee changes residence during the plan year, he or she may change plan enrollment within 31 days of his or her move under the following

conditions: if an enrollee moves from his or her plan's service area, he or she may enroll in any plan available in his or her new locality, or if a plan has not been available to the enrollee and he or she moves into that plan's service area, he or she may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date the enrollee moves.

3. If a court order requires a subscriber to provide medical coverage for an eligible spouse or child, the subscriber may change medical plans and add the dependent immediately, with the change effective retroactive to the effective date of the court order or the subscriber's effective date of coverage, whichever is later.
4. If a subscriber retires for any reason, the subscriber may change plans at the time of application for retiree coverage. The change will become effective on the first day of the month following the retirement date.
5. If an enrollee is covered under Medicare Part A and becomes enrolled in Medicare Part B, the enrollee may enroll in a Medicare Supplement Plan within six months of enrollment in Medicare Part B coverage.
6. Seasonal employees whose off-season occurs during open enrollment may change plans within 31 days of returning to work.
7. If an employee's medical plan becomes unavailable, the employee may choose another medical plan within 31 days after notification by the HCA. Anyone who does not choose another medical plan within this time period will be enrolled in the Uniform Medical Plan PPO by default. Anyone defaulted to the Uniform Medical Plan PPO may not change medical plans until the next open enrollment (except for one of the reasons listed above).

To change plans, subscribers must fill out an *Employee Enrollment/Change* form. Subscribers should contact their payroll, personnel, or insurance office for forms and information on how to update their records.

Note: Your contractual relationship is with the health plan you have selected, not the individual providers available through the health plan. If an enrollee's provider or health care facility discontinues participation with UMP PPO, the enrollee may not change health plans until the next open enrollment period. UMP PPO cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. Also, if an employee transfers from one agency or school to another during the plan year, the enrollee is not permitted to change health plans, except as outlined above.

When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
2. For an employee who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends for the employee and dependents (subject to the dependent's rights to continue coverage) at 12 o'clock midnight on the last day of the month in which the employee or dependent is eligible.
3. Premium payments are not prorated if an enrollee dies or terminates coverage prior to the end of the month.

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care," is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends, and the enrollee is not immediately covered by other health care coverage, benefits will be extended until:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan which will provide benefits for the services; or
- Benefits are exhausted, whichever occurs first.

When coverage ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the timelines explained in the following sections.

As a PEBB plan enrollee, it is the enrollee's responsibility to pay premiums when due. If the enrollee's account is delinquent, the enrollee's coverage will be

terminated at the end of the month in which the last full premium was received. **If the enrollee's coverage is terminated due to delinquency, the enrollee's eligibility to participate in the PEBB program will end.**

Options for Continuing PEBB Benefits

Employees covered by this plan have options for continuing coverage for themselves and their dependents during temporary or permanent loss of eligibility: (1) PEBB rules allow self-paid continuation of group coverage for up to 29 months during a temporary loss of pay; (2) the Family and Medical Leave Act of 1993 gives the enrollee the opportunity to extend eligibility with employer contribution toward premium for up to 12 weeks; (3) WAC 182-12-171 gives retired or permanently disabled employees and elected or appointed officials the right to enroll in retiree coverage; (4) the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives enrollees the right to continue group coverage for a period of 18 to 36 months; and (5) the enrollee has the right of conversion to individual medical coverage when continuation of group medical coverage is no longer possible. The dependents of employees also have options for continuing coverage for themselves following loss of eligibility.

Enrollees are not allowed to change medical plans at the time benefits are continued due to temporary loss of pay status or when the enrollee returns to active status. Enrollees will be allowed to change PEBB plans only as described in "Changing Medical Plans Mid-Year."

Continuing Coverage During Temporary Loss of Pay Status

When an employee temporarily loses pay status, PEBB group coverage may be continued at the group premium rate by self-paying premiums for a maximum of 29 months, except that part-time faculty may self-pay for group coverage between periods of active employee eligibility for a maximum of 18 months. If an employee is temporarily not in pay status for any of the following reasons, he or she may continue PEBB group coverage by self-paying the premium if:

1. The employee is on authorized leave without pay;
2. The employee is laid off because of a reduction in force (RIF);
3. The employee is receiving time-loss benefits under workers' compensation;
4. The employee is awaiting hearing for a dismissal action;
5. The employee is applying for disability retirement;
6. The employee is called to active military duty; or
7. The employee is on approved educational leave.

This 29-month period shall be reduced by the number of months of self-pay allowed under the federal COBRA law.

Employees who revert to a previously held position and do not regain pay status during the last month in which their employer contribution is made may continue their PEBB-sponsored medical coverage on the same terms as an employee who is approved for leave without pay.

Each of the employee's enrolled dependents is entitled to make a separate decision to exercise this continuation option.

Enrollees must apply for coverage within 60 days after the date that employer-paid benefits end.

When an employee returns to work:

- For employees on an approved leave without pay, the employer contribution will be reinstated on the first of the month in which they return to eligible employment. Except in the case of approved family and medical leave, and except as otherwise provided, only employees in pay status eight or more hours per month are eligible to receive the employer contribution.

Family and Medical Leave Act of 1993

Employer contributions toward PEBB plan coverage will continue up to the first 12 weeks of approved family leave in accordance with the Family and Medical Leave Act of 1993. Employees must also continue to pay the employee premium contribution during this period to maintain eligibility. After that, coverage may be continued as explained in the section titled "Continuing Coverage During Temporary Loss of Pay Status."

Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly fees hereunder are paid in full or in part by the employer, may pay the fees directly to the HCA if the employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

During the period the employee's compensation is suspended or terminated, the employee shall be notified immediately by the HCA in writing, by mail addressed to the last address of record with the HCA, that the employee may pay the fees as they become due as provided in this section.

Continuing Coverage Under a Retiree Plan

Retired or permanently disabled employees of state government, higher education, K-12 school districts, educational service districts, and participating employer groups are eligible for coverage in the PEBB retiree plans on a self-pay basis in accordance with WAC 182-12-171. A retired or permanently disabled employee is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person. More information about retiree eligibility is available online at **www.pebb.hca.wa.gov**, or by calling the HCA and requesting a *Retiree Enrollment Guide* at 1-800-200-1004.

An application to enroll in or defer retiree medical coverage must be received by the HCA **no later than 60 days** after active employment or continuous COBRA coverage ends. Employees who are approved a disability retirement must apply for coverage within 60 days after the date of the approval notice from the Department of Retirement Systems or their higher-education retirement system.

Appointed or elected officials of the legislative or executive branch of state government leaving public office may continue PEBB medical coverage on a self-pay basis whether or not they receive a retirement benefit from a state retirement system provided application is received by HCA no later than 60 days after the end of their term.

Retirees and/or permanently disabled employees and their eligible dependents must enroll in Medicare Parts A and B if entitled. A copy of your Medicare card will be required as proof of enrollment. A copy of the appropriate documentation from the Social Security Administration must be provided to the HCA if an enrollee or applicant is not entitled to either Medicare Part A or B.

Surviving Dependents

If a dependent(s) loses eligibility due to the death of the employee, the dependent(s) may continue coverage under a retiree plan provided the dependent(s) will immediately begin receiving a monthly benefit from any state of Washington-sponsored retirement system. The employee's spouse or qualified same-sex domestic partner may continue medical coverage until death; other dependents may continue medical coverage until they lose eligibility under PEBB rules. Surviving dependents must make application to enroll in PEBB coverage or defer the coverage, while enrolled in other comprehensive, employer-sponsored coverage or retirement from a federal retiree plan, within 60 days from the death of the employee. If a dependent does not receive a retirement benefit as described, see the "Options for Continuing Benefits" section.

Deferring Coverage At or Following Retirement

If the retiree elects not to enroll in PEBB retiree coverage within 60 days of becoming eligible or the retiree or his or her eligible surviving dependents canceled their PEBB retiree coverage, the enrollee is not eligible for PEBB coverage unless he or she defers PEBB retiree coverage as outlined below.

Beginning January 1, 2001, retirees may defer enrollment in PEBB medical coverage pursuant to WAC 182-12-205 if the following conditions are met. The retiree must be continually covered under another comprehensive employer-sponsored medical plan as an active employee or as the spouse or qualified same-sex domestic partner of an active employee, or as a retiree or as the spouse or same-sex domestic partner of an employee's retirement coverage from a federal retiree plan.

Pursuant to WAC 182-12-200, a retiree whose spouse is enrolled as an eligible employee in a PEBB or Washington State K-12 school district-sponsored health plan may defer enrollment in PEBB retiree medical plans and enroll in the spouse's PEBB or school district-sponsored health plan. If a retiree defers enrollment in a PEBB retiree medical plan, enrollment must also be deferred for dental coverage.

To continue retiree term life coverage, coverage must be selected upon retirement and premiums must continue to be paid during the deferment period. To defer medical and dental coverage, the retiree must submit a PEBB enrollment form indicating his or her desire to defer coverage to the HCA. This must be accomplished prior to the date coverage is deferred or within 60 days after the date he or she is eligible to apply for PEBB-sponsored retiree benefits.

Retirees and their eligible dependents who deferred medical coverage while enrolled in other comprehensive, employer-sponsored coverage may enroll in this plan within 60 days after the date other employer-sponsored coverage ends or during a PEBB open enrollment period. Proof of continuous enrollment in comprehensive, employer-sponsored coverage is required with application. Contact the HCA for information on the premiums and coverages available.

Retirees and their eligible dependents who defer PEBB medical and dental coverage while enrolled as a retiree or dependent in a federal retiree plan will have a one-

time opportunity to re-enroll in PEBB medical and dental coverage. To re-enroll in PEBB medical and dental coverage, retirees or their surviving dependents must submit an *Employee Enrollment/Change* form and proof of continuous enrollment in a federal retiree medical plan to the HCA either (a) during any PEBB open enrollment period, or (b) within 60 days after the date their other coverage ends.

Continuing Coverage Under the Federal COBRA Law

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments, employers are required (in most situations) to offer continuation of group coverage to enrollees losing eligibility for such coverage. When a "qualifying event" ends eligibility for coverage, the enrollee must contact the employee's payroll, personnel, insurance office, or the HCA at 360-412-4200 within 60 days of the qualifying event for information about the right to COBRA continuation and self-pay premium rates. If enrollees have the right to continue group coverage, they must submit an enrollment form within 60 days of the qualifying event. Enrollees are required to pay their own premiums, which begin accruing the first day of the month following the qualifying event. Failure to notify the payroll, personnel, insurance office, or the HCA may result in the loss of COBRA continuation privileges and retroactive denial of claims.

Qualifying events:

1. The employee and his or her covered dependents are entitled to continue PEBB-sponsored group coverage for up to 18 consecutive months if the qualifying event is: (a) reduction of the employee's work hours, or (b) termination of employment, except for discharge due to actions defined by the employer as gross misconduct. A second qualifying event during this 18-month period may extend the continuation period for dependents. Employees continuing their PEBB coverage under the federal COBRA law after termination of employment or reduction in hours, and who are disabled under Title II of the Social Security Act at any time during the first 60 days of COBRA coverage, can extend the continuation period an additional 11 months for all covered individuals. To qualify for the extended coverage, the HCA must be notified before the end of the initial 18 months of COBRA coverage and within 60 days of the disability determination.
2. The covered spouse or children may continue coverage for up to 36 consecutive months if the qualifying event is: (a) the employee's death, (b) divorce, (c) election of Medicare as the employee's primary medical coverage, or (d) a child's loss of eligibility for dependent coverage.

COBRA subscribers may add eligible dependents in accordance with PEBB rules after their continuation period begins. However, those added dependents are not eligible for further coverage if a second qualifying event should occur.

Continued coverage will end on the last day of the month for which premiums have been paid in which the first of the following occurs:

1. The applicable continuation period expires;
2. The next required premium payment is not made when due;
3. The enrollee becomes covered under another group medical plan, unless the new plan contains a preexisting condition exclusion or limitation that applies to the enrollee (in which case COBRA coverage will cease on the earlier of [a] the end of the COBRA continuation period, or [b] the cessation of the application of the preexisting condition exclusion); or
4. The former employer ceases to offer group medical coverage.

When continued coverage ends, enrollees may apply for conversion to individual medical coverage as described in the "Conversion of Coverage" section.

Each of the employee's enrolled dependents is entitled to make a separate decision to exercise his or her COBRA continuation option.

Extension of Coverage for Covered Dependents Not Eligible for COBRA

The following dependents are eligible for an 18-month extension of coverage if the employee loses coverage due to one of the following events: (a) reduction of the employee's work hours, or (b) termination of employment, except for discharge due to actions defined by the employer as gross misconduct. A second event during this 18-month period may extend the continuation period for dependents up to a total of 36 consecutive months if the event is: (a) the employee's death, (b) termination of a qualified same-sex domestic partnership, (c) election of Medicare as the employee's primary medical coverage, or (d) a child's loss of eligibility for dependent coverage.

- Covered dependents of an employer group subscriber who do not meet PEBB dependent eligibility as defined in WAC 182-12-260.
- Qualified same-sex domestic partner.
- Children eligible through a qualified same-sex domestic partnership.

When an event ends eligibility for coverage, the enrollee must contact the employee's payroll, personnel, insurance office, or the HCA at 360-412-4200 within 60 days of the qualifying event for information about the right to an extension of coverage and self-pay premium rates. Enrollees are required to pay their own premium, which begins accruing the first day of the month following the qualifying event. If enrollees have the right to continue group coverage, they must enroll within 60 days of the qualifying event, and will be required to pay their own premiums. Failure to notify the payroll, personnel, insurance office, or the HCA may result in the loss of continuation privileges and denial of claims back to the date of loss of eligibility.

Each of the employee's enrolled dependents is entitled to make a separate decision to exercise this continuation option.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered by UMP when they are no longer able to continue PEBB group (including COBRA) coverage, or are not entitled to Medicare or another group coverage which provides benefits for hospital or medical care. Enrollees must apply for conversion coverage within 31 days after their PEBB group (including COBRA) coverage ends.

Evidence of insurability is not required to obtain the conversion coverage. The rates, coverage, and eligibility requirements of our conversion program differ from those of the enrollee's current group program. Enrollment in a conversion program may limit the enrollee's ability to later purchase individual coverage through carriers available in this state without health screening or a preexisting condition waiting period. To obtain detailed information on conversion options under this plan, call PEBB at 1-800-200-1004.

Definitions

Adverse Benefit Determination

A denial, reduction, or termination of payment, coverage, or authorization for a benefit. It includes a failure to make a payment (in whole or in part) for a benefit.

Allowed Charge(s)

The maximum amount the UMP PPO allows for a specific covered service or supply. For professional services, durable medical equipment, supplies, and prostheses, allowed charges are the lesser of the provider's billed charge or:

- For *network* providers (**within and outside of Washington**), the applicable contracted fee schedule amount.
- For *non-network/out-of-network providers* **in Washington and the border counties of Oregon**, the UMP fee schedule amount.
- For *non-network/out-of-network providers* **outside of Washington and the border counties of Oregon**, a regionally adjusted charge (defined on page 68).

Note: The UMP fee schedule identifies certain services/procedures that are reimbursed on a case-specific (by report) basis. In this instance, the allowed charge may be based on UMP's fee schedule amounts for comparable services/procedures, billed charges (or percent of billed charges), Medicare's fee schedules, rates negotiated by case managers, and/or other method(s) at the UMP PPO's discretion.

Allowed charges for services from network hospitals and other facilities are determined by the provider's contract with UMP PPO, Beech Street, or Alternáre. For services from non-network or out-of-network facilities, allowed charges are generally based on the provider's billed charge, unless other arrangements have been made.

Allowed charges for prescription drugs are based on Express Scripts' standard reimbursement terms for its network pharmacies, unless other contractual arrangements or terms apply.

The UMP PPO fee for most drugs and biologicals administered other than orally by a provider is based on a percentage of the Average Wholesale Price (AWP) or a percentage of the Average Sales Price (ASP) determined by the Centers for Medicare and Medicaid Services.

The UMP PPO reserves the right to determine the amount payable for any service or supply.

Ambulatory Surgical Center (ASC)

A facility certified by Medicare or accredited by an accreditation organization recognized by the Centers of Medicare & Medicaid Services (such as the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]), that provides services for patients who receive invasive procedures requiring general, spinal, or other major anesthesia. (Examples of invasive procedures are biopsies, cardiac and vascular catheterizations, and endoscopies.) The ASC must be licensed by the state(s) in which it operates, unless that state does not require licensure.

Annual Medical/Surgical Deductible

A dollar amount you must pay each calendar year before UMP PPO pays medical/surgical benefits. Except for services specifically exempted in the "Summary of Benefits," the first $200 per individual in allowed charges for medical/surgical services (or $600 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual medical/surgical deductible and are your responsibility.

Annual Medical/Surgical Out-of-Pocket Limit

A dollar limit on the enrollee coinsurance and copayments you must pay for medical/surgical services each calendar year. The annual limit on the amount you are required to pay in coinsurance and copayments for medical/surgical services (in addition to your annual medical/surgical deductible) is $1,125 per individual or $2,250 per family. Once you have reached this limit, most claims from network and out-of-network providers are paid at 100% of allowed charges, except as otherwise specified in this *Certificate of Coverage*. For additional information see page 5 of this document. The following services and charges are *not* counted towards your or your family's annual medical/surgical out-of-pocket limit:

- Annual medical/surgical and prescription drug deductibles.
- Benefit reductions for failure to comply with medical review/preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.

- Enrollee coinsurance/copayments for retail and our mail-service prescription drugs.
- Enrollee coinsurance/copayments for services from non-network providers.

Annual Prescription Drug Deductible

A dollar amount you must pay each calendar year before the UMP PPO pays prescription drug benefits. The first $100 per individual in allowed charges for prescription drugs (or $300 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual prescription drug deductible and are your responsibility.

Appeal

An appeal is an oral or written request submitted by an enrollee or his or her authorized representative for UMP to reconsider:

- UMP's adverse decision regarding a complaint;
- A claim processing issue; or
- UMP's decision to deny, modify, reduce, or terminate payment, coverage, or authorization for health care services or prescription drugs.

Eligibility for enrollment in UMP PPO coverage is determined by PEBB.

Approved Provider Types (or Approved Provider)

See list on pages 18-19. A category of health care provider approved to deliver services under the UMP PPO. *Approved* providers include network, out-of-network, and non-network providers. Some approved provider types, such as massage therapists, must be network providers for the purpose of UMP PPO coverage.

Brand Name Drug

A particular drug product sold under the proprietary name or trade name selected by the manufacturer.

Calendar Year

January 1 through December 31.

Chemical Dependency

An illness characterized by a physiological or psychological dependency on a controlled substance or on alcoholic beverages.

Coinsurance

The percent of allowed charges that the UMP PPO pays for covered services. See also the definition of enrollee coinsurance (used to refer to the percent you pay or "enrollee cost-share").

Copayment

A dollar amount you pay when receiving specific services, treatments, or supplies, such as an inpatient hospitalization in a Washington or Oregon network facility, emergency room care, or a prescription filled through our mail-service pharmacy.

Custodial/Convalescent Care

Care primarily to assist in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervising medications that are ordinarily self-administered. The UMP PPO reserves the right to determine which services are custodial/convalescent care.

Domestic Partner

A qualified same-sex domestic partner is one who meets the requirements described on the *Declaration of Marriage or Same-Sex Domestic Partnership* form available from the HCA or your agency's personnel, payroll, or insurance office.

Durable Medical Equipment

Equipment that is:

- Designed for prolonged use;
- For a specific therapeutic purpose in treating your illness or injury;
- Medically necessary;
- Prescribed by the attending approved provider; and
- Primarily and customarily used only for a medical purpose.

Emergency

See Medical Emergency.

Enrollee

An employee, retiree, former employee, or dependent enrolled in the UMP PPO.

Enrollee Coinsurance

The percentage you are required to pay on claims for which the UMP PPO pays less than 100% of allowed charges.

Experimental or Investigational

A service or supply is experimental or investigational if any of the following statements applies when the service is provided. The service or supply:

- Cannot be legally marketed in the United States without approval of the Food and Drug Administration (FDA), and that approval has not been granted.
- Is the subject of a current new drug or new device application on file with the FDA.
- Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner intended to evaluate safety, toxicity, or efficacy.
- Is provided under a written protocol or other document that lists an evaluation of safety, toxicity, or efficacy among its objectives.
- Is under continued scientific testing and research concerning safety, toxicity, or efficacy.
- Is provided under informed consent documents that describe the service as experimental or investigational, or in other terms that indicate the service is being evaluated for safety, toxicity, or efficacy; or
- Is unsupported by prevailing opinion among medical experts (as expressed in peer-reviewed literature) as safe, effective, and appropriate for use outside the research setting.

In determining whether a service or supply is experimental or investigational, the UMP relies exclusively on the following sources of information:

- The enrollee's medical records.
- Written protocol(s) or other document(s) under which the service is provided.
- Any consent document(s) the enrollee or enrollee's representative has executed, or will be asked to execute, to receive the service.
- Files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service is provided, and other information concerning the authority or actions of the IRB or similar body.
- Up-to-date, published peer-reviewed medical literature (as defined on page 67) regarding the service, as applied to the enrollee's illness or injury.
- Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by the U.S. Food and Drug Administration (FDA), Office of Technology Assessment, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.
- Information the provider has shown proficiency in the procedure, based on experience and satisfactory outcomes in an acceptable number of cases.
- Opinions from medical adviser specialists.

Explanation of Benefits (EOB)

A detailed account of each claim processed by a medical plan, which is sent to you to describe claim payment or denial.

Family

All eligible family members (subscriber and dependents) enrolled in a single account.

Fee Schedule

UMP's maximum payment amounts for specific services or supplies. Network providers have agreed to accept these fees as payment in full for services to UMP PPO enrollees. See Allowed Charge definition for more details.

Formulary

See Preferred Drug List on page 67.

Generic Drug

Generic drugs have the same active ingredient as brand name drugs no longer under patent and are usually less expensive. Generic drugs use the official chemical title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary. Some are marketed under an alternate brand name.

Health Care Authority (HCA)

The Washington State agency that administers the following health care programs: Basic Health, Community Health Services, Prescription Drug Program, and Public Employees Benefits Board (PEBB). The HCA is also responsible for administering the Uniform Medical Plan PPO and UMP Neighborhood as medical plan options for PEBB enrollees.

Home Health Agency

An agency or organization that provides a program of home health care prescribed by an approved provider type (practicing within the scope of its license as an appropriate provider of home health services) and is Medicare-certified, JCAHO-accredited, or a UMP PPO network provider.

Hospice

A facility that provides short periods of direct or respite care for a terminally ill patient in a home-like setting.

This facility may be free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program, and it must be licensed by the state where services are performed or, if state licensure is not required, Medicare-certified or JCAHO-accredited.

Hospice Care Program

A formal Medicare-certified or JCAHO-accredited program directed by an approved provider to help care for a terminally ill patient. This may be through:

- A centrally administered, medically directed, and nurse-coordinated program that provides a system primarily of home care, uses a hospice team of professional and volunteer workers, and is available 24 hours a day, 7 days a week; or
- Confinement in a facility that operates as an integral part of the program to provide short periods of stay in a home-like setting for direct or respite care.

Hospital

An institution accredited as a hospital under the Hospital Accreditation Program of JCAHO and licensed by the state where it's located. Any exception to this must be approved by the UMP.

The term hospital does *not* include a convalescent nursing home or institution (or part) that:

- Furnishes primarily domiciliary or custodial care;
- Is operated as a school; or
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

Maintenance Care

Medical services designed to preserve or retain a current level of activity or health. The UMP reserves the right to determine which services constitute maintenance care.

Medical Emergency

The sudden and acute onset of a symptom or symptoms, including severe pain, that would lead a reasonable, prudent layperson to believe:

- A health condition exists requiring immediate medical attention; and
- Failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of bodily organs, or would place the person's health in serious jeopardy.

The UMP reserves the right to determine whether the symptoms indicate a medical emergency.

Medically Necessary Services, Supplies, or Interventions

UMP provides coverage for services, supplies, or interventions that are:

- Included as a covered service as described in the "Covered Expenses" section;
- Not excluded; and
- Medically necessary.

Except as provided under "Chemical Dependency Treatment" on page 23, a service is "medically necessary" if it is recommended by your treating provider and UMP's Medical Director or provider designee and if all of the following conditions are met:

1. The purpose of the service, supply, or intervention is to treat a medical condition;
2. It is the appropriate level of service, supply, or intervention considering the potential benefits and harm to the patient;
3. The level of service, supply, or intervention is known to be effective in improving health outcomes; and
4. The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. "Effective" means that the intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

A health intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "medical necessity," a health intervention is not considered separately from the medical condition and patient indications for which it is being applied.

An intervention, supply or level of service may be medically indicated yet not be a covered benefit or meet the standards of this definition of "medical necessity." UMP may choose to cover interventions, supplies, or

services that do not meet this definition of "medical necessity"; however, UMP is not required to do so.

"Treating provider" means a health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet UMP's definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, in the absence of such standards, convincing expert opinion.

A level of service, supply, or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for the patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

The fact a physician or other provider prescribes, orders, recommends, or approves a service or supply does not, in itself, make it medically necessary.

Preventive services not covered by the UMP PPO preventive care benefit will still be covered under the medical/surgical benefit if medically necessary.

The UMP may require proof that services and supplies, including court-ordered care, are medically necessary. No UMP PPO benefits will be provided if that proof isn't received or isn't acceptable–or if the UMP determines the service or supply is not medically necessary.

Network Provider(s)

Health care providers who have contracted with the UMP PPO (or are part of a provider network that has contracted with the UMP PPO) to provide services to UMP PPO enrollees at a reduced rate. When you use network providers, you cannot be billed for the difference between the provider's billed charge and the UMP allowed charge.

- For services received in Washington and Idaho counties of Bonner, Kootenai, Latah, and Nez Perce, UMP PPO contracts directly with network providers (except for alternative care providers who contract through Alternáre).
- For services elsewhere in the U.S., UMP PPO enrollees have access to network providers through the Beech Street network. Except for services received from Oregon providers, Beech Street discounts are not available when Medicare is the primary coverage.

Non-Network Provider(s)

Health care providers who practice within the service area of a network provider but are not contracted with UMP PPO or another UMP-contracted network (Alternáre or Beech Street), and who do **not** provide services to UMP PPO enrollees at discounted rates.

Normal Benefit

The dollar amount of the benefit UMP PPO would normally pay if no other health plan had the primary responsibility to pay the claim.

Open Enrollment Period

A period defined by the HCA when you have the opportunity to change to another health plan offered by PEBB for an effective date beginning January 1 of the next year.

Out-of-Network Provider(s)

Health care providers located outside of the U.S. or in geographic areas where there is no access to a network provider, as determined by the UMP (see definition of Service Area on page 68).

Over-the-Counter Alternatives

An over-the-counter product equivalent to a prescription drug (identical active ingredients and strength) available in a comparable dosage form.

Over-the-Counter Drugs

Medications available for purchase without a prescription.

Partial Hospitalization

Ambulatory services provided in a hospital setting which permit the patient to return to his or her residence at night.

PEBB Plan

One of several health insurance plans, including the state's own self-funded preferred provider plans, UMP PPO and UMP Neighborhood, offered through the Public Employees Benefits Board (PEBB) program to public employees, former employees, retirees, and their dependents. Benefits and eligibility are designed by the PEBB and administered by the Health Care Authority (HCA) as part of a comprehensive employee/retiree benefits package.

Peer-Reviewed Medical Literature

Scientific studies printed in journals or other publications where original manuscripts are published only after being critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature, for example, does not include information from health-related Web sites or in-house publications of pharmaceutical manufacturers.

Plan-Designated Facility

A facility, such as a hospital, which is designated for the performance of a particular service(s) for an enrollee. Coverage for these services is dependent upon use of the designated facility. Such a designation will be made by UMP Medical Review, Case Management, or the UMP Medical Director.

Preauthorization

Approval by UMP PPO for certain services before they are provided to the enrollee. Preauthorization is not a guarantee of coverage. Failure to preauthorize certain medical services or drugs could result in denial of the claim. Please see "Medical Review/Preauthorization Requirements" starting on page 19 for medical/surgical services that require preauthorization, and "Drug Coverage Management" on page 21 for drug classes that require preauthorization.

Preferred Drug List

A list of selected prescription medicines that assists the UMP in maintaining quality care while meeting cost-containment objectives for you and the UMP. The preferred drug list is reviewed regularly by an independent group of practicing health care providers to help ensure that the content is medically sound and supportive of your health. Enrollee coinsurance percentages and copayment amounts for brand name drugs vary depending on whether the drug is on the UMP Preferred Drug List (UMP PDL).

Prenatal

During the mother's pregnancy.

Primary Payer

The insurance plan required to process the claim first for all expenses allowed under its coverage when an enrollee is covered by more than one group insurance plan.

Professional Services

Non-facility medical/surgical services performed by professional providers such as medical doctors, doctors of osteopathy, naturopathic physicians, and advanced registered nurse practitioners.

Proof of Continuous Coverage

The Certificate of Creditable Coverage provided to the enrollee by the enrollee's prior health plan; or a letter from the enrollee's employer, on the employer's letterhead, providing the time period the enrollee and/or his or her dependent(s) were covered by health insurance.

Provider

An individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Regionally Adjusted Charge

The maximum payment for a specific service or supply allowed under UMP fee schedules, when performed by out-of-network providers and non-network providers outside of Washington and Oregon border counties. The UMP will establish regionally adjusted charges for each geographic area and service using one of the following:

- Medicare's allowable charge in the geographic region, inflated by a percent determined by the UMP;
- Charges most frequently made by providers with similar professional qualifications for comparable services in the provider's geographic area (based on the 75th percentile of data collected by Ingenix, an organization that maintains the Prevailing Healthcare Charges System);
- Most consistent charge made by an individual provider for a particular service;
- The provider's actual charge after any discounts or reductions; or
- The UMP, Beech Street, or Alternáre fee schedule.

The UMP reserves the right to determine the amount payable for any service or supply.

Respite Care

Continuous care for a homebound hospice patient of more than four hours a day to provide family members temporary relief from caring for the patient.

Service Area

The geographic area served by network providers. UMP PPO has contracted with Beech Street to provide access to network providers outside Washington State. However, in some areas services may not be available from network providers and may be paid as out-of-network (rather than non-network) benefits.

For purposes of out-of-network benefits for primary care provider services such as internal medicine, family practice, pediatrics, or obstetrics, adequate access to network providers is determined as follows:

- Urban: Distance from enrollee's residence to network provider is 30 miles or less.
- Rural: Distance from enrollee's residence to network provider is 50 miles or less.

For specialist services to be covered at the out-of-network reimbursement level, the distance from the enrollee's residence to a network provider must be more than 50 miles regardless of the urban or rural service area.

Skilled Nursing Facility

An institution, or part of an institution, that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility by Medicare. Skilled nursing facilities are not Medicaid-eligible, long-term care facilities.

Standard Reference Compendium

Refers to any of these sources:

- The American Hospital Formulary Service Drug Information.
- The American Medical Association Drug Evaluation.
- The United States Pharmacopoeia Drug Information.
- Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services.

Subscriber

The individual or family member who is the primary certificate holder and UMP PPO enrollee.

Substance Abuse Treatment Facility

An institution (or section) specifically engaged in rehabilitation for alcoholism or drug addiction that meets all of these criteria:

- Is licensed by the state;
- Keeps adequate patient records that contain course of treatment, progress, discharge summary, and follow-up programs;
- Provides services, for a fee, to persons receiving alcoholism or drug addiction treatment including room and board as well as 24-hour nursing; and
- Performs the services under full-time supervision of a physician or registered nurse.